

An insight into respect for the rights of trans and intersex children in Europe

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1. Background

1. This report is a follow-up to the international conference on “The right of the child and of the adolescent to his/her sexual orientation and gender identity” which took place in Sion (Switzerland) from 2 to 4 May 2013, and which was organised by the Institut universitaire Kurt Bösch (IUKB) in collaboration with the Council of Europe.
2. After presenting a short summary at the end of the conference, the author was asked by the Council of Europe to write this report in order to explain the key points made regarding the rights of trans and intersex children, but also to explore other aspects as well, and to provide guidelines for policy makers and examples of good practice that could be helpful to member states in framing policies and implementing activities to promote trans and intersex children’s rights. As the author had to work within a fairly limited framework, the report should not be regarded as exhaustive.
3. Addressing the issue of trans children from the perspective of their right to gender identity is crucial, and has ramifications in every area of the children’s lives. The rights of intersex children, as opposed to trans children, received relatively little attention at the Sion conference. Recher (2013) has emphasised the need for more systematic efforts to examine the situation of intersex children and to find solutions to the specific problems they face. The focus in the case of intersex children must be on upholding their physical integrity and respecting their bodies as they are, even if they do not conform to the norms associated with their biological sex. Intersex adults often talk about having had a highly medicalised childhood and there are serious concerns about respect for the rights of intersex children in this context.
4. Previously unpublished testimonies were gathered by the author from TRAKINE (Germany), SAIL (Northern Ireland), OUtans (France) and from three restricted access forums on Facebook, in which trans children and their parents talk about their experiences. The testimonies from intersex individuals were provided by OII Belgium. The statements were collected between July and November 2013.

2. Introduction

5. By their very existence, trans and intersex children challenge the way European societies are structured around what is known as the binary model of sex and gender. European societies, in fact, “are based on norms derived from the simplistic idea of a dichotomy of two mutually exclusive and biologically defined sexes to whom different roles and behaviour are traditionally ascribed” (AGIUS/TOBLER 2012: 9-15).
6. The author will use “trans” as an umbrella term to refer to individuals whose innate perception of their assigned sex, gender identity and/or gender expression differ from the sex they were assigned at birth. The term “intersex” will be used to mean individuals whose sex characteristics are atypical or at variance with commonly accepted norms.
7. A better knowledge and understanding of trans and intersex children is important in order to protect them against violence related to sex and gender norms. These norms may be defined as a set of what are perceived as mandatory rules about the way members of a particular sex are supposed to feel, behave and dress, for example. The normative aspect can be seen in the reactions to children who do not fit this model, and more especially in social and medical

“correction”. Such correction has the effect of denying the sex and gender diversity of intersex and trans children, thereby also denying their existence and rendering them invisible.

8. The Sion conference highlighted the need to give specific attention to the situation of trans and intersex children. For it has often been observed that the use of the term LGBT (“lesbian, gay, bisexual and transgender”) leads to recognition of many but not all of the problems encountered by trans children, leaving certain crucial aspects of their situation unnoticed and unaddressed. The LGBT acronym, moreover, runs the risk of conflating sexual orientation with gender identity. Increasingly, an “I” for intersex is added to LGBT, but that does not always translate into consideration for the particular circumstances of intersex people in practice. The lack of specific attention to the needs of both intersex and trans children has resulted in a failure to develop appropriate social provision.
9. Determining the best interests of trans and intersex children is a controversial business and turns on complex, fundamental issues such as “What are a child’s best interests?”, “Who decides them?” and “Who is in a position to know what those interests are?”. We will try to provide some facts and arguments to highlight the issues involved. It has been observed that often these issues are little known or misunderstood and that the children’s rights aspect tends to get lost completely in medical debates. A multidisciplinary perspective is essential here.

3. Trans children

10. A conversation between a mother and her 5-year-old trans daughter:

Child: “Why didn’t you give me a girl’s name when I was born?” Mother: “You had a willy” Child: “Yes, but inside, I’m a girl, in my heart and my head. When I was born, I already had a girl’s heart, but I couldn’t tell you” (TRAKINE 2012a).¹

3.1. Children with little-known or misunderstood characteristics

3.1.1. Definitions

11. Trans children experience a mismatch between what they feel themselves to be and what others expect of them, based on the sex that was assigned to them at birth (assigned sex). A number of terms need to be defined in this regard.

3.1.1.1. Gender identity

12. The notion of gender identity can be described as one’s private sense of being a man, woman or other individually defined gender, whether or not that corresponds to the sex assigned at birth.²
13. Some children may identify with the sex considered to be the “opposite” of the one assigned to them, but others have a less binary identity and individual situations vary greatly. Children are said to have a fluid gender identity, for example, when they are not permanently fixed in any one sex but think of themselves as sometimes female and sometimes male, or as a mix of male and female, or when they create new definitions for themselves (Brill/Pepper 2011: 37-41). The author received statements from several parents, personally confirming this.

¹ Originally in German.

² See definition provided by the *Jogjakarta Principles* (cf. glossary).

3.1.1.2. Gender expression

14. Gender expression can be defined as a series of signs, visible to others, associated with belonging to a given gender (male, female or other, as defined by the individual concerned). It might include, for example, the way a person dresses, speaks and behaves. This term “gender expression” serves to distinguish how a person feels about their gender identity from what they demonstrate through their outward appearance.³
15. Using this definition, the author will go on to look at gender behaviour as an aspect of gender expression.

3.1.1.3. Notion of “self-perception”

16. As well as the notions of gender identity and gender expression, the author will use the term “self-perception of gender”.
17. Some children are very young when they first express a disconnect between their assigned sex and their internal sense of who they are. The notion of “self-perception” is a way of remaining as close as possible to what the child feels and what they say about themselves, without boxing them into adult categories that are alien to them. With (gender) identity, there is a danger that others claiming to be experts will try to define the child’s identity for them, using existing labels. The notion of self-perception, on the other hand, invites us to adopt the language employed by the child, even if it differs creatively from existing adult concepts (Ehrensaft 2011, 2012). This approach, which takes as its starting point what the child says in their own words, and involves taking their expressed needs and wants seriously, is important when it comes to assessing the child’s rights.
18. No “expert” can decide for a child what their gender identity is, not even mental health professionals, who can merely relay what the child says and does. Ehrensaft (2012) puts it as follows: “individuals are the experts of their own gender identities and while gender expressions may vary over time, gender identity shows more temporal consistency. If we want to know how a child identifies, listen to the child, and if you pay close attention and provide a safe enough environment, over time he or she will tell you.”

3.1.1.4. Trans

19. It is important to bear in mind that the term “trans children” is generally applied *a posteriori* to young children and pre-adolescents, who may not necessarily use it themselves to describe their own situation. Usually they only become aware of the term in adolescence, when they might come across it in the media and start employing it themselves. Some will say, for example, that they are “a girl” or “a boy” or sometimes one and sometimes the other, etc. and not that they are “trans”.
20. Here is what one mother of a young trans girl had to say: “Lucy was three years old when she first told us that she was not a boy but a girl. At first, my ex-husband and myself thought it was just childish chatter and used to tell her “no, you’re a boy”, but she wouldn’t give up. She kept saying she was a girl, over and over” (TRAKINE 2012b).

³ A distinction needs to be made between gender expression (which is external) and gender identity (which is internal). A child’s gender expression may be fluid, without the child necessarily questioning the sex assigned to them at birth.

21. Since an umbrella term is required, the word “trans” is one that we feel is helpful and we will use it to refer to children who perceive themselves to be, identify with and/or express a gender different from the sex assigned to them at birth.⁴
22. One further point worth noting is that a trans girl is a girl who was assigned male gender at birth but whose self-perception, gender identity and/or gender expression is that of a girl, and vice versa for trans boys.

3.1.2. Number of trans children: the tip of the iceberg

23. More and more children are turning to specialist centres for medical assistance to help them transition⁵ (Spack 2012, Rauchfleisch 2013, Reed et al. 2009: 18), but the majority go undetected by their parents and those around them. As a result, it is not known exactly how many trans children there are, particularly as there is a multitude of terms, and they are not used consistently (they include trans-identified, transsexual, transgender persons, etc.).⁶ Brill/Pepper (2011: 16) estimate that at least one in five hundred children has a gender *identity* other than the one assigned to them at birth, not counting those children who merely have behaviour patterns that defy gender norms. It must be emphasised that this is only an estimate, but the number of trans children is certainly much higher than is generally supposed.

3.1.3. From early childhood to the onset of puberty: early awareness

24. Some children know from a very early age that the sex they were assigned at birth is not the right one for them. Authors report examples of awareness in very young children including, in one instance, a nine-month-old infant (Brill/Pepper 2011: 16 and 29-31, Ehrensaft 2012); it is possible that some children become aware earlier but are unable to communicate the fact to those around them.
25. There are, however, significant individual variations as regards age of awareness: in some children, awareness comes later, during childhood or adolescence, or not until adulthood (Keins/Schneider 2013, Kennedy 2013, Kennedy/Hellen 2010, Motmans 2009: 109). It is impossible to lay down general rules therefore.
26. There is a broad consensus among scholars that, at least until adolescence, there is no way of predicting with certainty which way a child will develop. Some children in this age group will go on to identify as trans later in life, others will not. Certain authors recommend helping parents to accept the child as they are and learning to tolerate uncertainty (Di Ceglie/Coates Thümmel 2006).
27. Trans children represent a very disparate group, consisting of numerous sub-groups in which children do not necessarily remain stuck their entire lives but which may be creatively redefined by the children themselves (Brill/Pepper 2011, Ehrensaft 2012). Once again, the terminology is not set in stone. The notion of “gender creativity” (Ehrensaft 2012) neatly encapsulates the fact

⁴ We have not included intersex persons per se in this definition although some individuals may identify with it. Biological sex variations are nevertheless a central aspect in characterising the situation of intersex persons and should not be forgotten.

⁵ See glossary.

⁶ Owing to the plethora of definitions and the limited scope of this report, the author will not attempt to address the complexities of current terminology.

that children are adept at finding original, unique and authentic ways of defining and expressing themselves.

28. To an adult looking in from the outside, the picture can seem complex or confusing. Some children have a binary perception of gender, others do not. Some do not identify with the sex assigned to them at birth and the kind of behaviours traditionally associated with that sex, and wish to transition socially from girl to boy or vice versa.⁷ Such children still define their gender in binary terms but wish to switch from one to the other. Gender fluid children, on the other hand, do not think of themselves as being either male or female but rather move along a continuum between the two. The way in which these children express their gender varies within this continuum, but that does not necessarily mean they do not identify with the sex assigned at birth.
29. Because trans children are such a disparate group, it is very difficult to identify them in the first years of life. Health and childcare professionals are not trained for this, yet an appreciation of the complexity of cases is crucial when it comes to assessing the specific needs of children at this age.

3.1.4. Adolescence

30. When children reach adolescence, the risk of suicide increases because of physical changes which exacerbate the distress felt by some children (see one mother's account in 3.1.5.). Hormone blockers can delay the onset of puberty, helping to reduce the child's distress and giving them time to consider whether they wish to undergo medical transition through hormone therapy and/or surgery (Brill/Pepper 2011-200-220, Cohen-Kettenis 2008, Reed et al. 2009, Reucher 2011, Spack 2012). Only a handful of specialist centres around the world offer this kind of care. Few health professionals are aware of them and adolescents, who very often will have done some preliminary research, frequently find themselves being denied treatment in a way that is not ethically neutral (Giordano 2008).

3.1.5. Invisibility

31. Whatever age children are when they become aware that they do not match other people's expectations about their assigned sex, they are not always able to verbalise this straightaway. It is not unusual for several years to pass before they acquire the necessary vocabulary and concepts (Grossman/D'Augelli 2006, Kennedy 2013, Kennedy/Hellen 2010, McBride 2013: 3). Kennedy (2013) describes the feeling of relief when that moment comes: "Reading about someone [...] in a magazine when I was 12 and feeling astonished that I wasn't alone". When it comes to telling those around them, many people report encountering negative reactions that prompt them to withdraw and to try to fit in: "When I first 'confessed' (around about 9) to some friends and my small brother, the reaction was pure horror, and I knew that I could never reveal anything again" or: "Somehow I knew that what I felt was simply not acceptable - and I was frequently told 'boys don't do that'" (examples cited by Kennedy 2013). The children in such cases are not identified as trans within the family or at school, which creates problems because the ensuing emotions, such as the feeling of being the only one in that situation or even abnormal, and the sense of not fitting in, can lead to depression, suicidal tendencies and high-risk behaviours (Kennedy/Hellen 2010, McBride 2013: 21).
32. Below, the mother of a trans boy tells her story:

⁷ Before puberty, it is only the social role that is apt to change, it being too early for medical procedures.

“My son was always a tomboy, he didn’t play with dolls but he loved football, marbles, toy cars, in other words, all the usual things that boys play with. He was also always keen on sport [...]. When his breasts began to develop, he used to beat them, presumably to try to make them disappear (that was around the age of 12, because he’s small and doesn’t have a big chest), he was happy as a child but the teenage years were difficult, with three suicide attempts and several stays in hospital (five to be precise, including one lasting six weeks). When his periods started, he reacted as if it were the end of the world (he couldn’t stand it [...]); he even skipped meals to lose weight and then his periods stopped for several months and he was happy but I was afraid he’d become anorexic [...]. He almost always wore fairly masculine clothing except for one time when he tried wearing make-up and dresses so as to fit in at school (it was difficult for him in sixth-form college because he was too masculine for the girls and too feminine for the boys, leaving him virtually alone, so he started experimenting with make-up, wearing dresses, putting streaks in his hair, etc... to make himself more feminine and get accepted), but he was very unhappy and that was when he started going off the rails (suicide attempts, posing on webcams with strangers because he didn’t like his body [...]). He discovered that he was trans from watching a TV programme and looking at videos on the internet. He was then able to put a name to what was wrong with him and begin coming out [...].”

33. The invisibility experienced by trans children can have serious consequences, therefore, and it is important that childcare and mental health professionals be taught to identify them. Such children generally display a few tell-tale signs discernible to the trained eye, such as an interest in the toys, clothes and activities associated with the sex considered to be the “opposite” of the assigned sex, in some cases accompanied by “unexplained” distress, depression or suicide attempts.

3.2. Gender norms and social correction

34. Social correction of children who deviate from gender norms begins in early childhood, takes numerous forms, such as verbal correction, punishment, mental and physical abuse, and is carried out by parents, other family members, peers, care providers, teachers, health professionals and strangers in public settings (Kid/Witten 2007, RADELUX II), prompting several authors to suggest that trans children are not safe (Grossman/D’Augelli/Salter 2006, Schneider 2013). Very little research has been done on this subject in Europe. Studies centred on actual childhood experiences of trans people are even rarer but confirm that such mechanisms do exist, and have an impact on the lives and health of both the children and their families.
35. An Italian study on childhood maltreatment in Male to Female (MtF) people,⁸ which sought to evaluate the prevalence of emotional abuse and/or neglect, physical abuse and/or neglect and sexual abuse, found that 27.5% had experienced childhood maltreatment and that such treatment had occurred on a regular basis in 57.7% of cases (Bandini et al. 2011). These figures for Italy are indicative of a certain type of abuse directed at trans children. All the studies on North America point in the same direction and will be cited throughout this report, on the assumption that their findings can be broadly extrapolated to Europe, in view of the personal information gathered by the author in relation to France, Germany, Luxembourg, Northern Ireland and Switzerland. Research remains to be carried out into the situation of trans children in the various countries of Europe.⁹

⁸ See glossary.

⁹ In the case of Northern Ireland, see Mc Bride 2013.

3.2.1. Depression, self-harm and suicidal tendencies

36. Suicidality is very high among trans children. According to an online survey conducted in France by HES/MAG (2009), 67 % of the trans 16- to 26-year-olds polled reported having already thought about suicide (in connection with their trans identity) and 34% reported having made one or more suicide attempts, mainly between the ages of 12 and 17. Grossman/D'Augelli (2007) also report a high rate of suicidal behaviour with suicide attempts from the age of 10 years. Clements-Nolle/Marx/Katz (2006) found that 47 % of the under-25s interviewed had attempted suicide. Little is known about suicidal behaviour in early childhood but the author heard first-hand accounts from parents on this subject.
37. Other behaviours are reported, often in connection with suicidal tendencies, such as anorexia or self-harm¹⁰ (Spack 2012, statements collected by the author). One parent gave the following account: "When she started secondary school [...], things went from bad to worse. Three suicide attempts in as many years and self-mutilation on her body in places where I couldn't see it".
38. Two causative factors have been identified as relevant in depression and suicidal behaviour in trans children. Firstly, there is a risk of suicide when trans children feel they cannot be their true selves and that they have to stifle or "kill" (RADELUX II 2012: 15) the part of them that is trans. Adolescents are not the only ones affected. The problem can also arise in younger children, as the following account by a parent of a trans child shows: "Over the course of the summer holidays, she completely changed her social role within the family and, at the end of the summer, she announced that she wanted to go to school as a girl. At the age of six, too, she wanted to write a book entitled "When I grow up... I will be a woman or else I will be dead".
39. Secondly, some studies have shown that there is a correlation between the violence experienced by trans people and their suicidal behaviour or depression. Grossman/D'Augelli (2007) found that trans youth who had attempted suicide had suffered more parental verbal and physical abuse than the other youngsters interviewed. Nuttbrock et al. (2010) found a statistically significant link between rates of gender abuse suffered by MtFs and rates of major depression and suicidality. Among the risk factors for suicide in trans individuals identified by Clements-Nolle/Marx/Katz (2006) are gender-based discrimination and physical abuse.
40. An important factor in reducing the risk of suicide in trans children is acceptance of the child, including the part of them that does not conform to gender norms. Children generally wish to adopt a first name that reflects their gender identity. Li et al. (2013) interviewed trans youngsters aged between 15 and 21 years and found that rates of depression, feelings of insecurity at school and of not belonging diminished the greater the number of environments where trans youth were permitted to use first names that fitted their gender identity. Likewise, Spack (2012) found that adolescents who sought and received hormone treatment from his clinic showed improved psychological functioning.
41. Trans children, therefore, should be regarded as a high-risk group for suicide and depression and mental health professionals should be trained to work with suicidal children in order to ascertain whether gender identity is a factor.

¹⁰ See glossary.

3.2.2. Confinement in psychiatric hospitals

42. Confinement in psychiatric hospitals raises the question of health professionals' lack of knowledge and understanding of trans identity issues. The following four situations are particularly problematic.
43. The first is the one mentioned earlier under "Invisibility" (3.1.5.), where suicidal behaviour is linked to trans identity but the latter goes undetected by the psychiatric services.
44. The second situation is one where a child is committed for suicidal tendencies and the hospital attempts to "correct" the child's behaviour on the ground that it is "too masculine" or "too feminine" (through sports therapy or a points system, for example; see RADELUX II 2012: 23-24).
45. In the third scenario, the child committed for suicidal tendencies has already identified their trans identity and makes this clear to the attending psychiatrist, who fails to take them seriously. The health care staff refuse to acknowledge the child's trans identity, and insist on calling them by the name that appears on the child's birth certificate, rather than their new preferred name, and on using the masculine or feminine pronouns associated with the name on the birth certificate (information provided to the author by OUTrans).
46. In the fourth case, children are confined regardless of whether they are suicidal or not for "observation" as part of a process of "diagnosing" trans identity.
47. The four scenarios described above can lead to trans children being confined in psychiatric institutions for up to several months, even when they only there for observation. Such cases could be avoided if there were better training for health professionals, greater social tolerance of gender expressions and identities and more information for parents.
48. Whatever the case, as long as health professionals fail to recognise trans identity as a primary factor in suicidal behaviour, they will be unable to provide the appropriate care to suicidal trans children, who will continue to be placed in psychiatric institutions, usually for excessively long periods.

3.2.3. Children in care and homelessness

49. Rejected by their families, some trans children risk ending up on the street, either because they leave the family home or because their parents throw them out. A disproportionate number of homeless children are trans. In order to survive, they sometimes resort to crime or prostitution (Ray 2006).
50. It also appears that a disproportionate number of children in care are trans. And since children's homes are generally ill-equipped to support them and have little knowledge or understanding of their needs, often the children are not accepted for who they are there either and run away (Mottet/Ohle 2003, McBride 2013: 23-24).

3.2.4. Psychological trauma

51. Further research needs to be conducted into the effects of the social correction experienced by trans children at multiple levels, but some scholars have already suggested that trans individuals

should be treated as potential trauma victims and that this is something that needs to be anticipated, especially in counselling (Mizock/Lewis 2008, Richmond/Burnes/Carroll 2011).

3.2.5. Trans children, a vulnerable group

52. Trans children must be viewed as a vulnerable group (Delvaux-Stehres 2013, Grossman/D'Augelli 2006) faced with major psychosocial risks. They must be taken into account when framing child welfare policies, which should be cross-sectoral in nature.

3.3. Family

3.3.1. The family: a place of acceptance... or violence

53. In early childhood, many children exhibit gender non-conforming behaviours which are usually corrected by their parents. Some of these children will be trans, although the parents may not necessarily have identified them as such. The behavioural correction based on gender norms will encourage some of these children to try to meet the expectations of the people raising them; for others, however, who are unwilling or unable to comply, the family is not a safe place to be (Mallon/DeCrescenzo 2006), with some authors pointing to the high incidence of violence within families (Grossman/D'Augelli 2007, Grossman/D'Augelli/Salter 2006).

54. In particular, when children announce to their parents that they want to transition,¹¹ it is not uncommon for parents to reject them, to refuse to allow the transition or to engage in emotional and/or physical abuse (statements collected by the author, Fuchs et al. 2013: 131-149, McBride 2013: 22). There have been reports of similar reactions from other family members, including sexual abuse (Bandini et al. 2011). This sexual abuse may be perpetrated by child or adult members of the same family. The author heard of a trans boy who was raped by an adolescent family member, in an attempt to "prove" to him that he was not a "real" boy. Generally speaking, trans individuals are often targeted by sex offenders because they do not conform to gender norms and it seems that children are particularly vulnerable to sexual abuse (Gentlewarrior 2009, Stotzer 2009).

55. Not all families respond the same way and parental reactions can vary greatly (Brill/Pepper 2011, Di Ceglie/Coates Thümmel 2006, Hill et al. 2010, RADELUX II, 2012: 13, Wren 2002). Some parents react by offering unconditional love and support, others go through a period of denial and may need time, in some cases several years, to digest the news and accept the child as they are. The shortage of professionals trained to deal with this issue has been cited as a problem by many parents looking for reliable information and guidance on how to act in the best interests of the child, and how to maintain good relationships both with the child and with those around them.

3.3.2. Parents under pressure and suspicion

56. There is considerable social pressure on parents to ensure their child conforms to gender norms (Kennedy 2013). If they support the child and allow them to live in the social gender role with which the child feels most comfortable, they are liable to be criticised not only by family members but also by health and childcare professionals. McBride (2013: 57) notes that "Suspicion has led service providers in some circumstances to erroneously view family members,

¹¹ See glossary.

particularly parents, as conditioning the young person's gender distress. Consequently, families that support the young person's self-determination are 'blamed' for the young person's gender identity. This can lead to suggestions of parental maltreatment and even of emotional abuse of the young person.¹² Such instances are fuelled by institutional ignorance of gender distress and trans issues.¹³ [...] Family members are thus also vulnerable to isolation and marginalisation if they support the young person on their journey."

57. Several parents of trans children, furthermore, told the author that the child welfare agencies had been contacted by the crèche or school because the parents allowed their child to live in a gender other than the one assigned at birth. In one case, officials threatened to have the child removed from the home. Similarly, TRAKINE told the author about a paediatrician who had accused a mother of "raising her child to be a schizophrenic" and of being "a serious danger to the child" and who had threatened to contact social services. From a psychiatric standpoint, it is incorrect to claim that a particular upbringing will make a child schizophrenic as it is not yet known what causes schizophrenia, which affects 1% of the world's population, irrespective of culture.
58. Child welfare professionals' lack of knowledge and understanding of trans issues thus places a heavy strain on parents and may even lead to family tragedies.
59. Parents are also at risk of being socially excluded (by family, neighbours, etc.). According to one statement collected by the author: "For years, the neighbours have refused to talk to us. It began when many of the parents of Mona's classmates complained about Mona sharing the changing rooms with the other girls during swimming lessons and using the girls' toilets. After some initial hesitation, the school decided to support us and to allow Mona to attend school as a girl, although they would not use her chosen name in her report cards".

3.3.3. Support for parenting

60. Trans children are vulnerable to abuse on many levels and families can be a very important factor for resilience, provided that these families are themselves a safe environment for the child and have ready access to information about how to perform their upbringing role in the best interests of the child. Access to trained professionals is essential therefore.
61. The author cannot cover here all the issues relating to family that ought to be explored in greater depth, in particular the negative impact on parent-child relationships when parents attempt social correction, the challenges facing siblings (Brill/Pepper 2011, Ehrensaft 2011: 177), and the high incidence of family breakdown (Whittle et al. 2007: 68-69).

3.4. Health system

3.4.1. Current practices: from ignorance and pathologisation to a more ethical approach

62. The experiences of trans children and their parents within the health system are intrinsically linked to two factors. Firstly, there is widespread ignorance about trans issues, with some parents and adolescents even being told, for example, that there is "no such thing" as trans

¹² NDA: The German organisation TRAKINE has reported cases of parents encountering similar reactions.

¹³ NDA: TRAKINE likewise reports a lack of awareness among health professionals.

identity in children. Secondly, the health system's treatment of trans children is shaped by the attitudes of health professionals towards variations in gender expression or gender identity. Whether such variations constitute an "illness" that needs to be treated has long been a contentious subject and has been hotly debated in medical circles.¹⁴ These discussions go beyond the purely medical sphere, however, as they have direct implications for children's rights. We will therefore provide a brief outline of the main arguments.

63. In these debates, it is contended that the definition of a mental disorder is not absolute, but is closely bound up with the norms of a given society, at a given time. There has been criticism of the lack of methodological rigour when developing "diagnostic" criteria,¹⁵ because it has never been established that variations in gender identity or expression are pathological in themselves, and they could in fact be seen as part of human diversity (Keins/Schneider 2013, Langer/Martin 2004). It is argued, for example, that on the contrary, it is social reactions that create pathological symptoms in the children in question (Langer/Martin 2004, Lev 2005, Wilson 2002). Another argument is that the diagnostic criteria are coloured by gender stereotypes (Keins/Schneider 2013) and reinforce the need for children, especially boys, to conform to gender norms (Wilson 2002). In short, there has been much criticism of the diagnostic criteria, to the effect that they are unreliable and invalid (Hill et al. 2007, Langer/Martin 2004).
64. This criticism is not without relevance when it comes to assessing the best interests of the child. For if the children's non-gender typical behaviours and identities are not pathological, then it becomes very difficult from an ethical standpoint to make "diagnoses" and to administer treatments designed to correct this behaviour, or even simply reinforce behaviour deemed appropriate to the sex assigned at birth (Keins/Schneider 2013).
65. A few therapists and medical centres currently specialise in this area and have broadly organised their services around approaches that are either normalising or accepting.

3.4.2. Controversial "normalisation" therapies

66. Historically speaking, the first approaches developed within the health system were based on explicitly correcting the child's behaviour (so-called "corrective", "reparative" or "conversion" methods). They involve checking for and repressing any behaviours associated with what is considered to be the opposite sex, systematically contradicting what the child feels about their own gender and constantly reaffirming the fact that they belong to the sex assigned to them at birth (for a brief history, see Bryant 2006). The underlying premise is that variations in gender expression and gender identity are pathological and need to be "treated".
67. Highly controversial since their creation (Bryant 2006), these corrective approaches still exist today and are considered damaging for children by a number of scholars (Ehrensaft 2011, Hill et al. 2007, Langer/Martin 2004, Lev 2004: 315-352, Mallon/DeCrescenzo 2006), as well as by the World Professional Association for Transgender Health (WPATH) which has declared such methods unethical (2009: 16).

¹⁴ Bryant 2006, Drescher/Cohen-Kettenis/Winter 2012, Hill et al. 2007, Langer/Martin 2004, Lev 2005, Motmans 2009: 18-28, Rauchfleisch (2009: 9), Sironi (2011: 27), Thomas/ Espineira/Alessandrin (2013), Wilson 2002. At the same time, Hammarberg (2009: 23) has noted that there is a problem with medical classifications.

¹⁵ Set out in the *International Classification of Diseases* published by the World Health Organization (WHO) and the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* or "DSM-5".

68. Following in the wake of corrective therapies, a further approach was developed for dealing with boys, whereby the father is advised to build a positive relationship with the child, and parents are advised to encourage positive interaction between the child and peers of the same biological sex, while ignoring gender-incongruent behaviours or trying to distract the child from them through other activities. The aim is to prevent the social stigmatisation of the child's atypical gender identities and expressions by trying to get the child to change themselves (Meyer-Bahlburg 2002).
69. The underlying principle is the same as that of so-called "corrective" approaches, to the extent that, once again, the idea is to "normalise" the child's behaviours in order to make them fit social norms.
70. This approach is no less fundamentally problematic than the first one, insofar as it challenges the child's self-perception and gender expression. The implicit message to the child is that they only deserve their parents' attention if they conform to gender norms.
71. The normalising approaches as a whole are essentially an attempt to force the child to submit to discriminatory social norms. No studies have been carried out to determine whether such approaches had a damaging effect on the children concerned, including those who did not go on to identify as trans in adulthood.
72. The author came across several alarming testimonies which would seem to indicate that both types of approach, namely the conventional corrective approach and the more recent normalisation approach, are still being used in Europe today.
73. One of these accounts concerns a young trans girl whose mother went to see the head of the psychiatric unit in a well-known teaching hospital. The doctor in question insisted that the child spend over a year in hospital, away from the parents, saying: "Contact between the parents and the child needs to be severed for a long period of time, so that the child can be broken and reconstructed by experienced professionals" [The term "broken" referred here to the child's trans identity].
74. The author does not have any information about the scale on which normalisation methods are employed by the psychiatric profession in Europe but he was very surprised and concerned to learn that these kinds of methods are apparently still in use today. It will be recalled that a link has been found to exist between suicidal behaviour and depression in trans children and social correction or normalisation measures linked to gender norms (see section 3.2.1).
75. According to Ehrensaft (2012), "significant harm is done to children when adults attempt to adjust the children's gender expressions and self-affirmed identities to match the gender listed on their birth certificates and from which the children show signs of transgression". She notes from her work as a psychologist that when children are prohibited from expressing their gender, "they show symptoms of anxiety, stress, distress, anger, and depression."¹⁶ This finding needs to be considered alongside the high risk of suicide among trans children. Rauchfleisch (2013) notes that ignoring the desires of these children can lead to depression or even suicide.

¹⁶ The author received witness accounts of similar experiences.

76. Most scholars point out that the long-term effects of normalisation “therapies” have never been assessed. The author considers that, in the absence of any evidence of the merits of such methods, they should be regarded as potentially harmful and traumatic for the child.
77. There is evidently a need to carry out research independently of the medical profession in order to shed light on the treatment of trans children or children with gender non-conforming behaviour in clinics and psychiatric hospitals, in particular in closed psychiatric units but also in outpatient facilities. The voices of the parents and the trans children themselves should be central in any such studies.
78. At the same time, however, it must be emphasised that there are medical centres and therapists out there who are developing accepting approaches, which should be seen as examples of good practice (see section 3.4.4.).

3.4.3. Other ethically questionable medical practices

3.4.3.1. Advising minors to have sexual intercourse

79. Various testimonies relating to medical practices involving trans children will be presented here.
80. The following account was given by a 16-year-old trans girl, in connection with an expert evaluation to determine her suitability for hormone therapy: “As part of the evaluation I had to fill out an online questionnaire, with, once again, lots of questions about sexuality. There were questions about sex with animals, babies, children, and about human and animal sperm. You would have thought the questions had been designed for sex offenders. Every appointment I had with him, Professor X [the doctor] would ask me if I’d had sex and try to persuade me that I should try it, whether with men or women. I told him several times that I would not use my genitals until I had been operated on. But he kept insisting that I should try it. He really put pressure on me.”
81. There is no medical justification for inquiring about perversions and sexual practices in an assessment to determine whether a young trans girl should receive hormone therapy. Such questions are also highly problematic from an ethical standpoint, especially where the subject is a minor. Besides being detrimental to the girl’s mental health, they are effectively a form of degrading treatment.
82. Also problematic is the fact that some doctors are encouraging youngsters to have sexual intercourse. This is not a totally isolated case because the author learnt from personal contacts with OII Belgium that doctors were giving similar advice to intersex youngsters. Once again, such unethical practices must be considered damaging to the adolescent’s mental health and an affront to their dignity.

3.4.3.2. Psychiatric consultations in front of an audience

83. A 16-year-old trans girl described her first appointment as an outpatient in a teaching hospital. What she had assumed was going to be a consultation turned out to be an interview before an audience of around twenty people, some of them barely older than herself. The doctor conducting the interview questioned her extensively about sexuality, in front of these other people sitting in on the session, and also her mother, who had gone with her.

84. "I was bombarded with questions, one after the other. Some of them were quite literally below the belt. It was horrible to be embarrassed like that in front of my mother and to have to respond, when I wasn't prepared." [The girl gave examples of the questions, such as:] "Do you ever have the desire to hold a man's penis?", "Do you ever have the desire to touch sperm?", "Have you ever wanted a man to touch your penis?" [...] Naturally I said "no". I was drenched with sweat from the ordeal, and in front of my mother too. The discussion lasted around an hour, I was really tense and afterwards I was ill for three days. My mother was a nervous wreck. I was shaking when I came out."
85. A more ethical approach would have been to ask both the girl and her mother for their consent, well in advance, before inviting other people to sit on the "consultation", particularly as the girl was a minor. The questions about sexuality, moreover, suggest there was some confusion with gender identity issues and were not necessary from a medical point of view. This was a serious breach of the girl's privacy, all the more so as the questions were put in front of her mother and an audience of some twenty people.

3.4.3.3. Non-medically justified examinations of genitalia

86. The author heard from a mother and father how a paediatric neurologist had examined their child's genitalia without consulting either the parents or the child first. The current practice is to seek the child's consent before conducting a physical examination, in particular a genital examination, out of respect for their privacy. Not to do so amounts to a breach of ethics. In the case in question, it is clear, too, that the examination was not medically justified as one had already been carried out by the general practitioner and it is not usually the job of the paediatric neurologist (who specialises in children's psychomotor development and behaviour) to examine a patient's genitals.
87. It is not uncommon for parents of trans children, and indeed trans adults, to complain about doctors showing an unhealthy curiosity in their genitals and about genital examinations being carried out for no medical reason, without seeking the consent of the child concerned and by doctors whose speciality is in a different area. Hammarberg (2009: 13) also flagged up this problem, citing instances of genital examinations being carried out by psychiatrists.

3.4.4. Good practices: accepting approaches

88. "Accepting approaches" means any which accept the child as they are and which respect the child's self-perception of their gender, gender identity and/or gender expression, with the child's own feelings being taken seriously. (Di Ceglie/Coates Thümmel 2006, Ehrensaft 2011 and 2012, Hill et al. 2010, Lev 2004, Mallon/DeCrescenzo 2006, Menvielle 2012, Möller et al. 2009, Pirelli Benestad 2012, Raj 2002, Torres Bernal/Coolhart 2012, *inter alia*). Some of these approaches expressly distance themselves from the pathologisation of gender identities and gender expressions that differ from the norm, taking the view that these are aspects of human diversity and that it is hostile social environments that are the problem and need fixing, not the trans children (Ehrensaft 2011 and 2012, Hill et al. 2010, Lev 2004, Mallon/DeCrescenzo 2006, Menvielle 2012, Pirelli Benestad 2012, Raj 2002, Sironi 2011, Torres Bernal/Coolhart 2012).
89. The general consensus among scholars is that it is impossible to predict with certainty whether a child whose self-perception is at variance with gender norms will identify as trans in adulthood. With accepting approaches, the child is free to explore whichever gender expression they feel most comfortable with, and to change their mind along the way.

90. Di Ceglie and Coates Thümmel (2006) make the point that “the main fact is the subjective reality of the child or young person, their own feeling of being male or female which could not be denied [...] the reality of the child or young person’s subjective self-perception should be respected and accepted as a fact outside any conscious control.” The authors go on to say: “However, there is also a need to allow space and time for exploration of identity and for possible development and change [...]”, emphasising that children’s experiences are varied, and that some “will remain fixed in one perception but that others will change” and that, given the difficulty of predicting outcome, there is a need to “tolerate uncertainty”.
91. The basic rule, then, when assessing the child’s best interests, is to respect the perception that the child has of themselves: it is their subjective sense of being a girl or a boy, or of not really falling into either of these categories, that must be acknowledged and respected. The same applies to behaviours that do not typically conform to gender norms.
92. Accepting approaches are the only ones which respect the best interests of the child, their right to identity (Article 8 of the International Convention on the Rights of the Child, hereafter the “UNCRC”), their right to protection against psychological duress (Article 19 UNCRC) and their right to be consulted in all matters affecting them (Article 12 UNCRC).

3.5. Education system

3.5.1. An emerging issue

93. It is quite clear that all institutions which cater for children, of whatever age, are capable of accommodating trans children: nurseries, kindergarten and other pre-school facilities (Graham 2012), schools (Brill/Pepper 2011), daycare centres and shelters (Mottet/Ohle 2003), boarding schools, etc. Dealing with children whose behaviour, identity or self-perception does not typically conform to gender norms must be seen as an emerging issue for all institutions that cater for children. It is also a challenging one: trans children who express a disjunction between how they perceive themselves and the sex that was assigned to them at birth are growing in number, confronting institutions with the question of how to respect the child’s self-perception as they themselves express it. At the same time, the majority of trans children go undetected, so identifying them is also an issue.

3.5.2. Bullying

94. Children who break gender norms run a high risk of being bullied at school and subjected to mental, physical and sexual abuse. This abuse can be homophobic in nature if the gender non-conformity is associated with homosexuality, but it can also have a specifically transphobic character if the child is believed, rightly or wrongly, to be trans. Kennedy (2013) draws attention to the problem of transphobia in school and describes behaviour ranging from kicking to destruction of personal property and even death threats. The author of this report also heard a number of personal accounts of transphobia:

“[...] Although I wasn’t aware of it, she was being horribly bullied at school. Not only was she insulted and ostracised by the other children, but she was also physically assaulted. The other children used to drag her into the toilets and pull down her trousers to look at her underwear and try to touch her genitals. [...]” (testimony from a mother).

95. "The bullying began around the age of 12 or 13. It started when some boys in my year spread rumours among the other pupils without saying anything to my face. Then some older pupils, 15- and 16-year-olds, began coming up to me and pushing me around both in school and on the bus, calling me names. Finally, and this is what really shook me, some 17- and 18-year-olds began shouting out my name in the corridor and the canteen. Everyone would stare at me and, most of the time, I felt embarrassed and ashamed".

96. Bullying can also be perpetrated by teachers (Whittle/Turner/Al-Alami 2007: 65, Motmans 2009: 75 and 167-168), as the following story, told to the author by a parent, illustrates:

"Her school was not very understanding; even when a doctor told them that my child was transgender, it made no difference. The bullying continued unabated, not only on the part of the other children but also on the part of certain teachers and the deputy head. When she reached the age of 14, I decided to remove her from the school system because of the torment to which she was being subjected daily by children and grown-ups alike. For the next six months, the local officials from the education department did nothing to ensure my daughter received the education to which she, like any other child, was entitled. No one called us. It was as though they preferred to be rid of what they saw as a problem child, rather than deal with the bullies who caused the problem in the first place. When we threatened to sue, the department of education conceded that the school where she was enrolled was not the best place for her. They never admitted, however, that they had failed in their duty to safeguard my daughter's right to education and to uphold her basic human rights, i.e. respect and dignity in a school that was under their supervision."

97. Various studies show that trans children suffer disproportionately from bullying at school. The feeling of insecurity that bullying induces in turn leads to disproportionately high rates of absenteeism and school dropout as well as increased risk of suicide (Fuchs et al. 2013: 113-123, Greytak/Kosciw/Diaz 2009, Kosciw et al. 2012, Hammarberg 2011: 111-116, Hammarberg 2009: 34-35, Latour 2013, Motmans 2009: 125, Taylor et al. 2009, Whittle/Turner/Al-Alami 2007: 62-67). Generally speaking, gender-based violence has short- and long-term consequences for the mental health and social well-being of trans children (see section 3.2.).

98. Transphobia in schools and other institutions for children can manifest itself in two ways. Firstly, through mental, physical and sexual abuse, often with the aim of "checking" what their "real" sex is or "proving" to them that they are not the sex they claim to be. Because of the risk of abuse, in particular sexual abuse, it is crucial that children be allowed to use the cloakrooms and toilets that correspond to the gender they appear to be/identify with, and that they be free to decide whether or not to disclose their trans identity to the other pupils. Secondly, transphobia can manifest itself through refusal to acknowledge the child's self-perception, as they choose to express it. Attitudes of this kind should effectively be considered a form of mental abuse and can involve, for example, refusing to use the child's preferred name and corresponding pronouns.

99. Specific programmes designed to prevent transphobia in school are required, therefore, in order to remedy the problem of transphobic violence, a major aspect of which is refusal to accept the child's identity.

3.5.3. Respect for the child's self-perception, gender identity and/or gender expression

100. Institutions which have trans children will typically receive requests from parents, asking them to use the child's preferred first name and corresponding pronouns (feminine, masculine or even neuter, depending on the language), to record the new first name on official documents (such as roll calls and report cards), to allow the child to participate in whichever activities the child prefers, in the case of boys-only or girls-only activities, and to allow them to choose which sex-segregated facilities they use.
101. Some institutions categorically refuse to accommodate the perception that trans children have of themselves. Kennedy (2013), for example, recounts the story of Samantha, who attends school as a girl and is accepted as such by the other children, yet the teaching staff continue to address her by her male first name, and the administration refuses to talk to the parents, preferring instead to send the child to see various social services and counsellors. Likewise, the association TRAKINE told the author about the case of a five-year-old trans girl who had been socialised as a girl at crèche from the age of three. The crèche was aware that the child, who used to come dressed as a girl and who had a female first name, was transsexual but the staff refused to call her by that name. Without any prior discussion and after rejecting all of the mother's suggestions concerning awareness-raising and training, the crèche summoned her to a meeting with two child welfare agencies, a meeting that was later cancelled when the mother wrote to explain that she would not be attending and why. In our view, this is an example of discrimination and institutional transphobia based on ignorance which is itself a product of the deeply entrenched nature of gender norms.
102. First and foremost, a trans child needs those around them to recognise and accept the perception the child has of themselves and the associated behaviours. What are needed, therefore, are care providers and teachers who are prepared to support the child fully and openly, and to take a flexible attitude to gender norms. Otherwise the risk of abuse will be that much greater (Alessandrin 2013).

3.5.4. "Panic" in schools: the need for initial and in-service training

103. Kennedy (2013, citing Payne/Smith, in press) describes the reaction of panic among teaching staff: fear of the danger of "exposing" the other children to the trans child, fear of how the other parents will react, the teaching staff's fear of what will happen if they are seen as being supportive, accepting or tolerant of a trans child, in a world where it is the child that is viewed as a problem, rather than the culture. Teaching staff and childcare providers but also other professionals who work in schools such as social workers, doctors and child psychologists, are usually unfamiliar with the subject of trans identity and gender non-conforming behaviours (Hellen 2009, McBride 2013: 35-36, Motmans 2009). In most cases, therefore, they do not have access to all the information required to make a comprehensive assessment of the child's situation.
104. Firstly, given that the majority of trans children go undetected, training is needed so that they can be identified at an early age. Trans children tend to be invisible because those around them do not know how to read their behaviour. For example, a four-year-old child considered to be a "girl" will systematically use the boys' toilets, or a primary school pupil considered to be a "boy" will draw a picture of a woman with long hair when asked to draw himself at the age of 20 (Latour 2013).

105. Secondly, teachers and childcare staff are liable to commit errors that can be detrimental to the child because they do not have the in-depth knowledge required to make good decisions, even though they may be well-intentioned and think they are acting in the child's best interests, for example, by disclosing the child's trans identity to the other pupils without the child's consent, and in so doing potentially exposing the child to the risk of bullying if appropriate preventive and/or remedial measures are not in place (RADELUX II 2012: 12).¹⁷ Only if teachers and care providers are trained to deal with trans children will they be able to handle these complex situations in a way that serves the best interests of the child.

3.5.5. Breaking the silence in schools

106. School curricula and textbooks generally make no mention of diversity in the context of gender identities and in particular trans identity. Including these issues and addressing them in a positive and non-pathologising way would allow children to verbalise their experiences and break out of their isolation, and help them to feel they have a place in society. Educating other pupils about these issues is also part of the wider effort to combat discrimination and prevent bullying. Given that some children exhibit their trans identity from the time they enter pre-school education, it seems sensible to start talking about it then, using appropriate teaching materials (Graham 2012, Kennedy 2013, Labelle 2013), and then continue the conversation at regular intervals throughout school.

3.5.6. Diplomas

107. Children who have their sex and first name changed on their birth certificate after leaving school need to have their diplomas amended accordingly. This is very important in order to protect their privacy and guard against possible discrimination in recruitment and harassment in the workplace. Hammarberg (2009: 43) has specifically called for "expeditious and transparent procedures for changing the name and gender of a transgender person on official documents". It is not enough here for the school to merely supply a document confirming the change of civil status, to be submitted in addition to the diploma, because that would require the individual to reveal their trans identity to future employers or training institutions.

3.5.7. Good practices

108. Various authors have suggested intervention models to allow trans children to successfully integrate in pre-school facilities and schools (Brill/Pepper 2011, Graham 2012, Luecke 2011, Pirelli Benestad 2012), with the focus on the child's safety and acceptance. Likewise, several school administrations have adopted rules whereby pupils are to be educated in keeping with their gender identity and allowed to choose which sex-segregated facilities they use (see also "Model District Policy on Transgender and Gender Nonconforming Students" published by the Gay, Lesbian & Straight Education Network (GLSEN)/National Center for Transgender Equality 2013).

109. Other examples of good practice include two laws. Article 12 of the 2012 Argentinian law on gender identity (see translation in the appendix) states that children and adults have the right to

¹⁷ The stance taken by Luxembourg's education minister is to be welcomed in this context. Replying to a parliamentary question, she agreed to the request for children's trans identities to be normally treated as confidential (Delvaux-Stehres 2013).

use the first name that corresponds to their gender identity, even if it differs from the one stated on their birth certificate, and that public and private institutions must respect this choice. Meanwhile, California's Assembly Bill 1266, which was introduced in 2013, grants children the right to participate in sex-segregated school activities, including sport, and to use facilities consistent with their gender identity, irrespective of the gender listed in the pupil's records.

110. Another example of good practice can be found in Luxembourg. In 2013, the minister for education gave the go-ahead to allow the school guidance and counselling centre (CPOS), which covers state-run secondary schools, to bring together schools and the organisation Intersex & Transgender Luxembourg a.s.b.l. with a view to improving the situation of trans children, based on actual experiences.

3.6. Conclusion: assessing the child's best interests

111. It is in the best interests of the child that their self-perception of their gender, gender identity and gender expression be unconditionally recognised by the parents, education and health professionals, and by society at large. If that is the case, respect for the child's mental integrity (Article 19 UNCRC), their right to preserve their identity (Article 8 UNCRC) and their right to be consulted in all matters affecting them (Article 12 UNCRC) will follow. The key components here are information, training and regulations governing the implementation of the children's rights.

3.7. Recommendations

Vulnerable group

112. Promote the dignity of and respect for trans children in all areas of their lives, which means respecting their self-perception, their self-determination, their gender identity and their gender expression. These aspects should take precedence over biological sex when assessing the child's best interests.

113. Treat trans children as a vulnerable group requiring special protection.

114. Put an end to the inhuman and degrading treatment suffered by trans children, especially in the health system, pursuant to states' obligations under the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment.

115. Promote a structured dialogue with groups and organisations representing trans children and their parents in order to develop appropriate policies.

116. Take into account the specific needs of trans children when developing child welfare policies, which should be cross-sectoral in nature.

117. Treat trans children as a high-risk group for suicide and include them in suicide prevention programmes.

118. Incorporate in initial and in-service training for professionals working with children information about trans children, taking care to ensure that variations in gender identities and gender expressions are presented in a positive and non-pathologising way. This applies not only to staff in the welfare, education and health sectors but also to legal experts working in these fields.

Support for parenting

119. Encourage the development of a front-line counselling network, independent from the medical community, specialising in the issues encountered by trans children, their parents and persons close to them. The counselling should be based on the principle of unconditional acceptance of the trans child, i.e. respect for their self-perception of their gender, gender identity and gender expression, and on preventing the psychosocial risks to which the children and their families are exposed. The counselling should be designed in co-operation with representatives of the parents of trans children and should be adequately funded.

Education

120. Encourage respect for gender expressions that do not conform to gender norms and respect for the gender identity of trans children, whatever their age, among staff in all institutions that cater for children, in particular through initial and in-service training.

121. Promote the development of guidelines on how to deal with trans children in all institutions catering for children, with particular emphasis on the use of first names and corresponding pronouns (feminine or masculine), and the child's privacy and safety.

122. Include in school curricula and textbooks information portraying trans children and adults in a positive and non-pathologising way.

123. Train professionals in institutions that cater for children and child welfare agencies to deal with trans children and related issues.

Health

124. Conduct research, independently of the medical profession, into the "treatments" administered to trans children by mental health professionals.

125. Incorporate in initial training for health professionals information reflecting the current debates about the pathologisation of trans children and the psychosocial risks that they face; raise awareness of these issues among people already working in the health sector.

126. More specifically, incorporate in initial and in-service training for mental health professionals a section on the psychosocial welfare of trans children, taking a non-pathologising approach and paving the way for psychiatric, psychological and psychotherapeutic support based on the principle of unconditional acceptance of the trans child, i.e. on respect for the child's self-perception of their gender, gender identity and gender expression, and on prevention of the psychosocial risks to which the child and their family are exposed.

127. Specifically include trans children in suicide prevention programmes as a high-risk group.

128. Specifically include trans children in policies designed to prevent gender-based violence, in particular violence within families.

Research

129. Carry out participatory research on the social status of trans children. Such research should be designed in such a way as to include more than two gender categories.

130. Provide for more than two gender options in any research involving children and adults.

4. Intersex children

4.1. Introduction

131. One of the features of the lives of intersex people throughout Europe and the world is invisibility. “The fact that people hardly ever think or talk about intersex people is the last stage in a long process which renders such people’s lives invisible, ranging from the obliteration of their physical features by hospitals, through the passing on of incomplete or piecemeal information to children about the medical processes they have undergone or the fact that they were kept in ignorance, to being ordered to say nothing outside their own homes and the taboo surrounding the existence of intersex people in the public sphere” (Guillot/Bastien-Charlebois 2013: 253).
132. On the whole, the public at large are not aware of the existence of intersex people and there is a glaring lack of research on the subject. The taboos surrounding their situation and the shame engendered by social and medical norms which consider their bodies to be abnormal are major obstacles for intersex people to be able to become more visible and make their voices heard. The adoption by the Parliamentary Assembly of the Council of Europe of Resolution 1952 (2013) on children’s right to physical integrity (Parliamentary Assembly, 2013) was an important milestone in the process of raising the profile of intersex children and recognising their existence at European level.
133. We will deal with several aspects of their medical, social and legal situation, bearing in mind that the limited framework of this report makes it impossible to address every issue. We have had to confine ourselves to giving a general outline of current discussions, and there are many matters it has been impossible to discuss, such as abortions, prenatal diagnoses (Zobel, in press), prenatal treatment (Dreger 2012) and ethical problems connected with medical research on intersex children (Tamar-Mattis 2012). We believe, nonetheless, that the practices in these areas play a major role in the perception of the complex medical issues at stake and that they contribute to the process whereby intersex people are rendered invisible.

4.1.1. Terminology

134. As stated above, we will define intersex (or intersex) children as children whose sex characteristics are atypical or at variance with commonly accepted norms (for a more descriptive definition, see the glossary). This definition calls to mind that what is considered to be female or male is determined by norms relating to a person’s biological sex gender and that these norms derive from a socio-cultural construct (also known as the “binary gender model”, Agius/Tobler 2012: 9-15).
135. There are a large number of forms of intersex variation (ISNA, Australian Senate 2013: 1-10) and there is no consensus as to what variations of sex development should be regarded as intersex. We have chosen not to use the abbreviation “DSD” because it is rejected by a large number of intersex persons on account of its pathologising connotations (Australian Senate 2013: 21-27). Whether it is taken to mean “disorders of sex development” or “differences of sex development”, the connotation does not entirely disappear.

4.1.2. Number of intersex people

136. It is impossible to know for certain how many intersex people there are. Firstly, there is no systematic collection of data on the subject and secondly, any attempt at data-gathering would be intrinsically tied up with the definitions used, on which there is no consensus (ISNA, OII Australia 2013b). With regard to the number of births of children whose genitalia at birth cannot be classified as female or male, the generally accepted estimate is one in 1500 or 2000. As to the number of people undergoing corrective genital surgery, it “probably runs between 1 and 2 per 1,000 live births (0.1–0.2%)” (Blackless et al. 2000). The total number of intersex people depends on the forms of intersex variation that are taken into account, hence the major variations depending on the author. Blackless et al. (2000) have suggested a figure of 2%, which is an estimation.
137. The lack of data is problematic because it is one of the factors which contributes to the invisibility of intersex children and their social stigmatisation. The problem is compounded by the way in which states and institutions carry out surveys. To take part in most surveys, participants must state their gender and the only options they are given are male or female. Persons who do not answer this question are automatically excluded from the survey. Studies in which only two genders are recorded are not a true reflection of reality and contribute to the failure to take intersex people into account and their invisibility.
138. A good practice is to record the number of children born with a gender that cannot be considered male or female and to publish these figures (Center for Epidemiology and Research 2011). However, these children account for only a small share of intersex children and specific systems need to be devised to collect the data needed to calculate their numbers as they are currently classified administratively as being either male or female.

4.2. Health systems

4.2.1. Norms, variations and pathologies

139. When it is found that certain gender-related physical characteristics in a child or an adolescent have not developed in the “usual” manner, a series of examinations is generally carried out. When the difference with (what is considered) the “norm” for the male or the female gender exceeds a certain limit, doctors consider that they are dealing with a pathology, which requires treatment in most cases (Westenfelder 2012: 77-82).
140. Although phenomena linked with intersex variation correspond to variations of sex development, the medical community controversially interprets these physical variations as the sign of an “illness” even when the person’s organs are healthy and functional, when it is in fact the medical treatment aimed at curing the “illness” which gives rise to the appearance of actual iatrogenic pathologies. Woweries criticises the fact that “medicine considers anything which casts doubt on the binary system of sex categorisation as abnormal, unnatural and pathological” (2012: 71). This is an allusion to the criticism that has been voiced concerning the definition of intersex variation as an illness (see also Fausto-Sterling 2012: 121-138, Australian Senate 2013: 3-4). The question is whether the variations connected with what is referred to as a person’s “biological gender” are truly an illness.

141. The answer to this question determines not only the way in which intersex children are treated medically but also whether their rights are respected. The idea of a “true” gender¹⁸, reduced to either male or female and with which certain physical attributes and medical procedures are too automatically linked, hampers any consideration about children’s rights to self-determination, which must be tied up with the right to be protected from “all forms of physical or mental violence, injury or abuse [or] maltreatment” (Article 19 UN Convention on the Rights of the Child - UNCRC).
142. Another viewpoint would be possible, in which what doctors regard as “anomalies” could be viewed in a positive manner as simple variations. The medical doctrine concerning the treatment of intersex children centres all too frequently on standard ideas about biological gender (Fausto-Sterling 2012: 78-101, Tamar-Mattis 2012). For many doctors, it is unthinkable that the bodies of intersex children will not yield to these notions, whereas in fact there is a need to devise other norms catering for diversity so as to adapt to their real circumstances and meet their needs.

4.2.2. Medical procedures

4.2.2.1. Statement of the problem

143. Medical procedures on intersex children can differ in type. Some are essential to keep the child alive while others attempt to prevent serious damage to the child’s physical health (for instance when the child’s urinary tract is blocked or partly blocked). The legitimacy and necessity of such procedures are not called into question provided that they are linked with and proportionate to current health problems (Moron-Puech 2010: point 55).
144. The situation is different where it comes to so-called normalising operations, which are regarded from a legal viewpoint as cosmetic surgery because they do not have any therapeutic purpose (Lembke 2011, Moron-Puech 2011). They consist in giving children’s genital organs appearance as close as possible to that of a female or a male while removing from the body any internal organs that are at odds with their apparent gender. Taken as a whole, hormonal and surgical treatments diverge in their practical application.
145. Such procedures are based on the idea that they are enabling children to have a good quality of life. Plattner (2008: 16) tells us that she was given the following advice by a doctor: “Just bear in mind that if anyone hears about it, it will be the end for your child, from a social viewpoint. Think of school, sport or swimming!” Rupprecht (2013, point 6) has pointed out that such procedures are (well-)intended, socially accepted but very often medically unjustified.
146. Normalising procedures carried out in childhood have been especially condemned by persons for whom they have had devastating effects. Christiane Völling describes very clearly what happened to her (2010 : 94):
- “The castration [removal of undescended testicles] which I underwent and the paradoxical administration of high doses of testosterone which was considered necessary as a result led to physical and psychological disorders such as hot flushes, depression, sleeping disorders, early osteoporosis, lost sexuality and ability to reproduce, trauma linked to the castration, lesion of the thyroid glands, changes in my cerebral metabolism and my bone structure and many other

¹⁸ For a historical overview, see Voss 2012 : 194-136.

lesions and side effects. Taking testosterone resulted in the growth of hair that was typically masculine and a masculine beard, the loss of all my hair as a result of the effect of androgens, an increasingly masculine timbre in my voice, which had previously been feminine, increasingly male facial features and the production of male anatomy despite female predispositions. My surgically constructed male genital organs caused irreversible damage such as chronic urinary infections, micturition disorders, stenosis and scarring. As a result of these procedures I lost any inherent feeling of belonging to a gender and any sexual behaviour.”

4.2.2.2. Bodily integrity

147. The prevalence of side effects, multiple surgical procedures and long-term after-effects has been highlighted by various authors, as well as a lack of studies, particularly long-term ones, showing that such procedures are warranted for children (Australian Senate 2013: 35-76, Creighton 2004, Intersexuelle Menschen e.V. 2011, Carpenter 2013, Schober 2012, Tamar-Mattis 2012, Woweries, in press). “For most of us the postoperative after-effects last decades or, frequently, a lifetime“ (Guillot 2008 : 43).
148. Various operations are considered, depending on whether it has been chosen to make a child male or female. Masculinising operations can be lengthy (involving the construction of a penis or phalloplasty based on a micropenis). The criteria on which decisions to opt for masculinisation are based have been criticised as being cultural in nature (Fausto-Sterling 2012 79-85). At the same time, there is a legitimate fear that children will be subject to harassment and mockery because of the small size of their penis. The question is how to go about changing cultural norms and the environment of intersex children instead of allowing discriminatory concepts to impinge on their bodies.
149. In a number of cases, normalising procedures for intersex children involve removing certain sex parts of the body, not because they pose any threat to the child’s physical health but because they do not match the norms associated with the gender that has been chosen for the child.
150. Medical dictionaries define mutilation as “the removal or loss of a member or part of the body”. Mutilation is medically justified when it is performed for a therapeutic purpose but, where intersex children are concerned, it is most often carried out in order to make the child’s body comply with sex norms, and it is for this reason that it is contested.
151. The mutilation undergone by intersex person has been described as “intersex genital mutilation” (OII Intersex Network 2012) or “western genital mutilation”(zwischenGeschlecht.org 2012) and it is a part of these organisations’ priorities for an immediate halt to be brought to such procedures.
152. Some procedures on intersex children do indeed involve removing the clitoris completely (clitoridectomy) or partly (excision). These operations are carried out on intersex children who are born with a macroclitoris or a micropenis which does not fit into the medical categories of male or female genitalia and are assigned as female. These types of procedure have certain features which could lead them to be regarded as the type of traditional practice prejudicial to health prohibited by Article 24 of the UNCRC. Just like female genital mutilation (Werlen 2008), procedures on intersex children can cause total or partial loss of sensitivity, chronic genital and urinary infections, the need for further operations, painful sexual relations and similar psychological repercussions such as trauma, anxiety and depression (Deutscher Ethikrat 2012a-fr: 75, Intersexuelle Menschen e. V. 2011). They are also carried out for cultural reasons and derive from a certain tradition: accounts confirm that operations on macroclitorises or

micropenises have been carried out in Europe since Antiquity and probably before (Klöppel 2010: 215-216, Voss 2012: 31-36), and they became widespread in the second half of last century.

153. Another type of procedure which poses problems is gonadectomy¹⁹. As in the example of Christiane Völling, described above, a large proportion of intersex children receive gonadectomies on the ground that their gonads are inconsistent with their apparent gender or the gender that has been chosen for them.
154. Gonadectomy equates to sterilising children, sometimes at a very early age. Most frequently the aim is to match children's bodies with pre-established norms and only in some cases is the purpose to prevent reasonably foreseeable damage to their physical health²⁰ (Intersexuelle Menschen e. V. 2011, Tamar-Mattis, 2012). For people who would have liked to have children, it is a cause of distress when they reach adulthood to know that it may have been possible had the gonadectomy not been performed without consulting them.
155. After a gonadectomy, hormone replacement therapy is essential as the body no longer produces enough hormones. However, no scientific studies have been carried out on the effects of such treatment on children and still less on intersex children, and hormone therapy is not covered by the rules on licensing for the marketing of medicines (Intersexuelle Menschen e. V. 2011). The result is that such treatments are experimental in nature and do not respect the protective rules laid down by the Helsinki Declaration, which are stricter for children (World Medical Association 2008, paragraphs 19 and 20).
156. Furthermore, practices seem to vary from country to country and hence be somewhat arbitrary. In France, hormone replacement therapy is systematic in such cases during childhood. "Once we have been sterilised, we depend on hormone replacement treatments which are very burdensome, reduce the quality of our lives and often result in serious medical conditions caused by the side effects of synthetic hormones, operations and the fact that the body does not react as expected" (Guillot 2008). In Germany, on the other hand, children are generally not given hormones until they reach puberty and they appear to be exposed to a risk of osteoporosis. In addition, the lack of hormones overloads the suprarenals, which take over from the missing gonads for part of the hormone production process, and the rate of kidney problems among intersex people is abnormally high (Intersexuelle Menschen e. V. 2011).
157. Feminising procedures involve carrying out a vaginoplasty, in other words creating a vaginal opening. When the operation is performed in early childhood, the neo-vagina must be kept open throughout childhood using a dilator, which must be inserted regularly by the child's mother. On reaching adulthood, many intersex people report that this process was extremely painful and akin to a form of rape (Guillot 2013: 33-34, Tamar-Mattis 2012). Parents have also said that they had the impression that they were committing rape on their child (Tosh 2013). In addition, post-operative complications are frequent and surgery often has to be performed again when the child reaches adolescence because it was not successful (Creighton/Liao 2004). "In adolescence, if the 'girl' wishes to continue to have a cavity, new operations have to be carried out and it now becomes her turn to dilate herself for the rest of her life with a replica of

¹⁹ See glossary.

²⁰ This is where gonads are removed because of a risk of cancer (Deutscher Ethikrat 2012: 47-48). However, it would seem that this risk has been generalised and exaggerated for some categories of people, that it emerges only during adolescence and that writers recommend that the situation is monitored rather than operating in early childhood (Intersexuelle Menschen e.V. 2011).

the member which was taken away from her in early childhood without it ever being revealed to her that she was castrated. Even if, by chance, the medical team has matched the person's body with her gender identity, she will go through living hell with this badly made body and will often abandon the regular dilations, have no sexual relations and experience many urinary problems including, in the worst cases, incontinence" (Guillot 2008: 43). Some teams postpone vaginoplasty until adolescence but the problem of the adolescent's informed consent arises because of the unbalanced relationship of authority between doctor and patient.

158. In the absence of any long-term studies proving that normalising procedures are good for children's health, if we bear in mind that they are irreversible and have a serious impact on health, it is difficult to explain why people agree to such procedures and are willing to live the rest of their lives with the consequences.

159. According to Bastien-Charlebois (2013), "By being made into exceptions, we intersex or intersex persons who have undergone sex changes without our consent, learn early on that our bodies do not belong to us, that they are so repulsive in the eyes of our parents or the medical authorities that they believe that it is perfectly justified for them to undermine our physical integrity. We learn that our opinion and the view that we have of our own bodies do not count and this is so even when we become adults, when doctors still regard us as perpetual children, incapable of showing discerning judgment where it comes to our own affairs".

4.2.2.3. Mental integrity: wrong sex assignment

160. The wrong gender is assigned to children in 8.5% to 20% of cases, or even in 40% (depending on the category of "DSD" used as the basis of one of the rare studies), in other words these children ultimately reject the gender assigned to them²¹ (Tamar-Mattis 2012, see also Fausto-Sterling 2012: 91-94). Major infringements of children's mental integrity result from this. In this connection, the author collected the following statement:

"I was assigned female at birth but very quickly, it was clear that my behaviour tended to be that of a male. Alongside the surgery, my parents were strongly advised to bring me up in a manner which was geared more to femininity. This began with the toys and the clothes they chose for me and continued with moving me from a mixed school to a school for girls, carefully monitoring my recreational activities with the boys in the neighbourhood (no football or so called boy's games) and registering me for so-called girl's extra-curricular activities (such as knitting and sewing). Despite all this, my male identity remained. During this period, my Mum was accused by medical professionals of not being strict enough. When I was ten or eleven, my Mum saw that I was unhappy and above all lonely because I did not have any friends, and slackened the reins a little, which allowed me to make new contacts. Except for school, she gradually respected my choices more and more but it was a long road. I've forgiven her now as I know she was only following the practices of the time and it was impossible to find any other

²¹ This invalidates the psychological theory which has prompted the spread of normalising procedures, namely that children can only grow up healthily with either a female or a male identity and the only way of achieving this is for children to have genitalia which are clearly identifiable as either female or male (Beh/Diamond 2000, Fausto-Sterling 2012 : 67-101, Voss 2010 : 529-236). The physical suffering caused by this maltreating theory cannot be emphasised enough. Karkazis (2008: 133-176) has noted that this theory is now no longer systematically relied on to justify surgery and hormone treatment. According to many surgeons she questioned, children must appear to be "normal" for their proper "psychosocial development". When this matter was referred to the Swiss National Advisory Commission on Biomedical Ethics (2012: 14-15), it found that priority should be given to the child's physical integrity.

information (through the Internet, books or the media). Our relationship was sorely tested when I learnt the truth about my intersexuality. The fact that I was intersex did not shock me as much as finding out that I had been lied to all my life, and although I have forgiven my mother our relationship was knocked back by this”.

161. Children raised in this way with a gender which does not fit them experience a complete denial of their identity combined with coercive practices such as bans on certain types of toy, wearing certain types of clothing or mixing with certain types of people. Gosselin (2012: 90) has emphasised how “tremendously violent” it is “to impose a gender on somebody through medical treatment and socialisation and refuse to allow them to change it”.
162. A child’s gender identity should be regarded as a part of the right to identity protected by Article 8 of the UNCRC (Werlen 2008: 181). Yet, there is nothing at birth which makes it possible to predict what a child’s gender identity will be. Some children will identify with the gender considered to be “opposite” and then during adolescence or adulthood, they will begin on the reverse path. However, any organs taken away from them are removed once and for all. Others will identify themselves as being intersex or outside traditional binary sex categories despite having been assigned a gender during childhood (Richter-Appelt 2011). Irreversibly choosing a morphological gender for children is incompatible both with their right to identity and with their right to respect for their mental integrity (Article 19 UNCRC).

4.2.2.4. Concealment and problems accessing medical files

163. Some parents have been told that their intersex child “was something from the realms of ‘teratology’ (the science of monsters)” (Picquart 2009: 21). This medical concept is supposed to have disappeared and been replaced by the idea that unusual bodies are pathologies which need to be treated, but it would seem that some traces of it remain (Beh/Diamond 2006, Fausto-Sterling 2012: 58 ; 68-69). Whatever the case, the implied message that their body is unacceptable has been taken on board by many intersex children. The feeling of being a monster or abnormal is a recurring subject in intersex people’s testimonies (Bart et al. 2013, Karkazis 2008: 216-235, Picquart 2009) and the theme of monsters is found in the work of certain artists such as Ins A Kromminga (2012 and 2013).
164. The feeling of being abnormal is enhanced by concealment. Firstly, a significant number of people report that they – or their parents – were not informed that they were intersex, that their doctors gave them incomplete information and that they were not informed of the nature of the surgery and hormone treatment they underwent²² (Gosselin 2012: 54-56, Karkazis 2008: 179-235, Picquart 2009: 27-34). Concealment is explicitly recommended by most doctors (according to Alderson et al 2004: 94-95 and Fausto-Sterling 2012: 73: 86-88). When the persons concerned discover the truth later on, they often state that they are shocked or traumatised because they have been lied to (Fausto-Sterling 2012 : 328, Picquart 2009: 65-71). Preves (1998, as quoted by the Ministerial Advisory Committee on Gay and Lesbian Health 2002) has collected accounts from intersex people who said that “being encouraged to keep silent about their differences and surgical procedures only served to enforce feelings of loneliness, stigma, and shame”. Intersex associations call on medical professionals to provide us with full information:

²² This practice is based on the idea that this would damage the psyche of the child or the adult (Beh/Diamond 2000, Fausto-Sterling 2012: 87). This premise has not been borne out scientifically and is refuted by cases of children who have not been operated on who manage their intersex variation positively (Lang 2006: 120). This is a further argument for not operating during childhood and waiting for the persons concerned to make their own choice.

“Tell us the whole story. Don’t insult our intelligence with lies. When speaking to children develop staged, age-appropriate information. But lying never works and it can destroy the relationship between patient and parents and patient and physician” (statement cited by Fausto-Sterling 2012: 110). The German Ethics Council also recommends that people should be fully informed (Deutscher Ethikrat 2012a-fr: 180). Likewise, some medical articles argue in favour of this approach (Beh/Diamond 2000, Alderson et al 2004, D’Alberston 2010).

165. A frequently reported problem in this area is the refusal of medical professionals to hand over medical files (Kolbe 2010: 136-137) or their disappearance or destruction. The German Ethics Council has stated that it is the responsibility of states to keep medical files and it has recommended that they should be kept for 40 years (Deutscher Ethikrat 2012a-fr: 166-168,180).

4.2.2.5. Trauma as a result of medical practices

166. Many intersex children are traumatised by the circumstances in which medical examinations of their genitalia are carried out (Ehrenreich 2004: 108, Fausto-Sterling 2012: 111, Klöppel 2010: 30, 195-196, Tamar-Mattis 2012), as they have characteristics similar to sexual abuse, with equally serious mental consequences (Alexander 1997).

167. The author collected the following statement from Oll Belgium:

“Intersex children are often subject to mentally traumatising procedures, which have ‘paedopornographic’ aspects. Having to be photographed and examined regularly from all angles in the presence of students and assistants has long-term mental consequences similar to those experienced by child abuse victims. The life-time consequences are a poor body image and the feeling of being a freak, making a fulfilled sex life difficult and leading to unhealthy lifestyle choices and problems such as smoking, alcohol and drug abuse, anorexia and bulimia. There is also a refusal to consult doctors even in the event of a serious health problem and a lack of trust when forced to do so in spite of everything. Today, aged 55, and having undergone all these degrading treatments up to the age of 17, I can confirm that the mental consequences are real. This has also been confirmed to me by other ‘victims’. I still have regular nightmares about that time in which I see dozens of piercing eyes staring at my genitals. I have also developed a phobia of cameras to such an extreme that it is even very difficult for me to have an identity photo made”.

168. Guillot/Bastien-Charlebois (2013: 249) also highlight medical practices such as examining children in front of medical students, making comments in front of children and taking photos of naked children, some of which can be recognised later in medical books. These authors say that “adult intersex persons talking about these experiences describe them as very trying and traumatising”.

4.2.2.6. The role of parents

4.2.2.6.1. Parental consent

169. The right of parents to give their consent to normalising surgery and hormone treatment which cannot be categorised as therapeutic is disputed, as parents’ decision-making powers are not absolute and decisions must be taken in the child’s best interests (Deutscher Ethikrat 2012: 152-160).

170. One of the reasons why parents wish to normalise their children’s appearance is the fear that they will be stigmatised, particularly at school. Another reason can also be their own difficulty in

accepting the child's genitalia (Karkazis 2008: 179-215). When the question is raised at birth, some authors also refer specifically to the fear that parents may not be able to establish proper ties with children who are left in a "neutral" state (Bouvattier 2011).

171. However, Karkazis points out that doctors "instruct parents early on to view their children as abnormal or pathological and requiring intervention, intervention that may help to 'restore' the child". As she states, "construing such a birth as a rare physiological abnormality not only paints the event as one that requires medical intervention but also works to isolate the parents and their child socially by identifying them as anomalous" (2008: 182-183).

172. In these conditions, the way in which it is announced that a person is intersex plays a major role in how the news will be received. Guillot (2012) states that "the future of the family and the child to be are fundamentally tied up with the announcement. Generally, such announcements are made in a perinatal medical context and in terms which make it very difficult for the family in the broadest sense to accept the child. ... where the announcement is dedramatised and positive [the multidisciplinary team at the Lausanne University Hospital] notes, like the team in Toronto, where there has been a protocol for such cases for an even longer time, that the child is greeted quite differently, with far less commotion, and requests for medical treatment decrease considerably".

173. As to fears that children will be stigmatised, these must be weighed against children's recognised rights. The right to physical integrity prevents parents from giving lawful consent to irreversible procedures considered to be "cosmetic" such as those in question. This is particularly so when the effect is to sterilise the child (Moron-Puech 2011, Lembke 2011, Deutscher Ethikrat 2012a-fr: 152-160), but also because it entails major risks and there is no proof that it will be beneficial for the child (Beh/Diamond/Richardson 2005). Furthermore, under Article 12 UNCRC, children have the right to be heard about any matter concerning them: "1. States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child". In a significant number of cases, children reject the gender assigned to them and regret the choice that was made for them. This makes it particularly important to apply Article 12, with the implication that we must always wait before any irreversible procedure is carried out.

174. The Swiss National Advisory Commission on Biomedical Ethics has expressly stated that children's physical integrity must take precedence over considerations linked to the reactions of their entourage (2012: 14-15):

"The limiting factor in the consideration of family/cultural circumstances will be the physical and psychological integrity of the child. An irreversible sex assignment intervention involving harmful physical and psychological consequences cannot be justified on the grounds that the family, school or social environment has difficulty in accepting the child's natural physical characteristics. The harmful consequences may include, for example, loss of fertility and sexual sensitivity, chronic pain, or pain associated with dilation (bougienage) of a surgically created vagina, with traumatizing effects for the child. If such interventions are performed solely with a view to integration of the child into its family and social environment, then they run counter to the child's welfare. In addition, there is no guarantee that the intended purpose (integration) will be achieved".

175. The question of informed consent also raises problems in adolescence because of the medical establishment's position of authority and the social norms pushing young people towards normalisation (RADELUX I 2012 : 21).

4.2.2.6.2. Support for parenting

176. The discovery of a child's intersex variation has been described as a "tsunami"²³ for the child's family. At whatever age the discovery is made, families are generally not prepared for it and it is often a shock or a trauma for the parents – and one for the children concerned when they discover it after some delay. Generally speaking, parents have never heard anything about intersex variation in children and the difficulty of coming to terms with the situation is described by one mother as follows:

"When my child was born, everything I knew about gender identity was cast into doubt. Today, I know that I did not and still do not have any model for my thoughts about intersexuality. The birth of my child put me in what can only be described as a state of shock, not because I did not want this child – on the contrary, in fact – but because I did not have a framework for my ideas about this new circumstance. I could not and still cannot at all, conceive of a way of being in this world without the male and female categories. ... Perhaps therefore the greatest problem lies in our heads. The child is not ill but we cannot conceptualise it when it does not clearly belong to either of the categories"²⁴ (Pulvermüller 2012: 256).

177. The absence of intersex people from collective representations puts pressure on parents and is one of the factors which gives rise to normalisation procedures. A major campaign should be run to raise awareness about the existence of intersex children in a society polarised by the gender dichotomy and it is important to devise specific parenting aids.

4.2.2.7. Consent during adolescence

178. Some intersex adolescents report that they agreed to surgery during adolescence and regretted it later because they were not able to give informed consent (private [communications](#) with OII Belgium). The asymmetry in the doctor-patient relationship plays a major role in this type of decision, together with the pressure to conform to society. The conclusion is that safeguards should be established to ensure that an adolescent's consent can be truly informed and formal consultation will not be enough on its own. Compulsory consultation might be set up, for instance, with the national institution responsible for protecting children's rights.

4.2.2.8. Acknowledgment of damage done

179. The Swiss National Advisory Commission on Biomedical Ethics (2012: 20) and the German Ethics Council (Deutscher Ethikrat 2012a-fr: 104-108) have stated that it is essential for the suffering caused to intersex persons by medical practices to be acknowledged. In this connection, the German Ethics Council recommended setting up a compensation fund (Deutscher Ethikrat 2012a-fr: 181). As to the UN Rapporteur against Torture, he has stated that normalisation procedures could constitute acts of torture or ill-treatment (Mendez 2013).

²³ Guillot 2012.

²⁴ Originally in German.

4.2.3. Interim conclusion: the best interests of the child

180. The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health has pointed out that "... informed consent is not mere acceptance of a medical intervention, but a voluntary and sufficiently informed decision. Guaranteeing informed consent is a fundamental feature of respecting an individual's autonomy, self-determination and human dignity in an appropriate continuum of voluntary health-care services" (cited by Mendez 2012, paragraph 28).
181. Normalising surgery and hormone treatment carried out on intersex children who are not able to give informed consent are in breach of children's best interests (Article 3, UNCRC), their right to be heard and to take part in decisions relating to them (Article 12, UNCRC) and their rights to be protected against physical or psychological duress (Article 19 UNCRC) and against traditional practices prejudicial to the health of children (Article 24.3 UNCRC). Added to this is the aspect of discrimination (Article 2, UNCRC), namely that normalisation procedures are based on the theory that intersex genitalia are unacceptable and therefore there is a difference in the way in which intersex genitalia and others are treated.
182. The fact that parents give their consent to infringements of children's rights does not necessarily render them lawful.
183. The Swiss National Advisory Commission on Biomedical Ethics has expressed the following opinion (2012) on normalisation procedures:
- "3. The following basic principle should apply to the management of DSD: on ethical and legal grounds, all (non-trivial) sex assignment treatment decisions which have irreversible consequences but can be deferred should not be taken until the person to be treated can decide for him/ herself. This includes genital surgery and the removal of gonads, unless there is an urgent medical indication for these interventions (e.g. increased risk of cancer²⁵). Exceptions to the general rule would be cases where a medical intervention is urgently required to prevent severe damage to the patient's body or health.
4. Protection of the child's integrity is essential. Given the uncertainties and imponderables involved, a psychosocial indication cannot in itself justify irreversible genital sex assignment surgery in a child who lacks capacity."
184. The Parliamentary Assembly of the Council of Europe expressed a similar opinion in Resolution 1952 (2013) of 1 October 2013. This resolution sets particular store by the right to bodily integrity, autonomy and self-determination and marks the recognition at European level of the seriousness of the situation in which intersex children currently find themselves. Article 7.5.3 also invites the member states to "undertake further research to increase knowledge about the specific situation of intersex people, ensure that no-one is subjected to unnecessary medical or surgical treatment that is cosmetic rather than vital for health during infancy or childhood, guarantee bodily integrity, autonomy and self-determination to persons concerned, and provide families with intersex children with adequate counselling and support".

²⁵ Author's note: It is possible to conduct regular checks instead of a gonadectomy.

4.3. Social situation

185. To gain an insight into the situation of intersex people, it is necessary to consult intersex organisations and published accounts. Very little research has been done on the psychosocial situation of intersex people and the studies that have been produced relate only to a small number of people. Below is a discussion of some of the problems reported by the persons concerned.

4.3.1. Violence

186. Sexual violence is frequently reported in the accounts of intersex people (private communications by the author with French-speaking OII). Rosenstreich (2013: 9) reports that “some intersex people feel that intrusive examinations combined with stigma and secrecy within the family also made them vulnerable to sexual abuse as children”. Similarly, Pitts et al. (2006: 50) have noted that the intersex people they interviewed report higher levels of physical assault and sexual violence (see also Jiménez/Cabral 2013).

187. Information passed on by some intersex people and organisations seems to indicate that violence within families is frequent (private communications with French-speaking OII; see also Gosselin 2012: 90). However, the reactions of parents to the discovery that their child is intersex may vary and some parents accept their children as they are (Guillot/Bastien-Charlebois 2013).

188. Having studied submissions from intersex people, the New Zealand Human Rights Commission concluded that: “the secrecy and shame associated with intersex conditions left intersex people, especially children, vulnerable to discrimination and abuse” (Human Rights Commission 2007: 80).

4.3.2. Psychological distress, depression, self-harm and suicidal tendencies

189. The psychological distress of intersex people is considerably higher than the average (Kennedy 2006). According to a pilot study by Schützmann et al. (2009), the level of psychological distress of intersex adults is equal to that of non-intersex women who have been traumatised by physical or sexual abuse. Suicidal tendencies and self-harming practices seem to be considerably above average among intersex people (Schützmann et al. 2009), as well as levels of depression (Pitts et al. 2006: 31). In some cases, people regard depression as a direct consequence of medical procedures (Deutscher Ethikrat 2012a-fr: 75).

4.3.3. Intersex children, a vulnerable group

190. Intersex children must be viewed as a vulnerable group to be catered for when drawing up child welfare policies, which should be cross-disciplinary in nature and devised in co-operation with intersex organisations. All persons working with children should be trained on the situation of intersex children, including not only staff from the welfare, education and health sectors but also legal experts in these fields.

4.4. Education system

4.4.1. Issues

191. In the absence of studies on the situation of intersex children in the education system, here are the subjects of concern communicated to the European Commission, as recorded by the German organisation representing intersex people, IVIM (Internationale Vereinigung Intergeschlechtlicher Menschen, 2010):

- “Absence from school due to surgery/ies²⁶ leading to difficulties regarding the consistency of their studies and their ability to follow their education as regular pupils;
- High levels of stress due to cover-up stories for the time of absence. This is mainly due to the fact that intersex realities are still considered a taboo and many intersex people are not properly informed about medical reasons for or details of the treatment that they are provided with;
- Intersex children and youths sometimes do not fit the standard gender expression of the sex they are aligned with, and hence they are exposed to very high risks of bullying, mobbing and other forms of discrimination²⁷;
- Intersex people who cannot (or do not want to) pass as either male or female due to their gender expression and/or sex, experience embarrassing and dangerous situations due to the ignorance of administrative and teaching staff and/or discriminatory school regulations/practices (e.g. in access to gendered toilets, or other sex segregated facilities). This is often coupled with discrimination that is intersexphobic, transphobic and/or homophobic coming from other pupils and/or staff;
- School sex-segregated sport facilities (e.g. sex segregated dressing rooms, sex segregated sports and games, gendered sport attire) can also heighten the experience of discrimination;
- Wrong use of pronouns to address intersex persons can lead to both embarrassment and exposure to bullying and mobbing, and is disrespectful and hurtful.

192. It needs to be noted that not all intersex people experience the full set of discrimination described above. This is due to the fact that many intersex people do pass both outwardly and in their gender expression as one of the socially defined male or female sexes, with or without medical treatment. However, the deeply embedded binary sex segregation in our societies implicates fundamental problems for intersex people, such as the stress caused by the taboo around intersex experiences, that directly or indirectly create difficulties for all intersex people in various spheres of life, including in education”.

193. Furthermore, surgery is generally scheduled for the summer holidays and preceded by medical examinations during the Easter holidays. As a result, holidays for intersex children are often synonymous with stays in hospital, making it a problem for them to do homework during these periods. In addition, operations are often followed by complications, which result in absences from school (private communications with OII-Belgium).

²⁶ Author’s note: And hormone treatment.

²⁷ Author’s note: This results in total isolation and a very high suicide risk.

4.4.2. Training of childcare and teaching staff

194. One of the reasons why some parents authorise surgery on their children is the fear of what might happen to them in pre-school and school (unhealthy curiosity, stigmatisation, bullying). Childcare and teaching staff should be trained in ways of dealing with intersex children and their parents, and on issues related to protecting children's privacy and safety.

4.4.3. School curricula and textbooks

195. School curricula do not usually reflect the existence of intersex people and intersex children do not have positive models with whom they can identify. Where the intersex variation of human beings is dealt with at all, it is often during biology lessons, but in a pathologising way with vocabulary centring on these people's "anomalies". This approach merely adds to the stigmatisation and shame surrounding intersex children. Moreover, by ignoring the existence of intersex people in key subject areas (such as birth or the development of sex characteristics), biology lessons inevitably provide false information. For example, a sentence such as: "From birth, girls may be distinguished from boys through their primary sex characteristics" (Vanin 2011: 127) is inaccurate, discriminatory and problematic from an ethical viewpoint. The omission of babies to whom it is impossible to assign a gender which tallies with pre-established norms concerning the so-called female or male genders causes situations of exclusion for the children concerned. When they are faced with this type of text, the implied message is that there is no place for them in our society as they "do not exist".

196. It should be emphasised that biology curricula are not the only ones that should be reviewed. Intersex people should be granted their place across all subjects and be presented in a positive light, as part of the wealth of human diversity.

197. A very substantial effort needs to be made to improve school curricula and textbooks, which should be pursuing at least the following goals:

- raise the profile of intersex children and adults, portraying them in a positive, non-pathologising light from their earliest childhood on;
- prevent their social stigmatisation and, in particular, the violence to which they are subjected in families and society and at school, and the discrimination to which they are subjected on the basis of gender norms.

4.5. Legal aspects

198. The legal situation of intersex children is complex and should be the subject of a specific investigation which would extend beyond the framework of this report (for an overview of the issues, see Deutscher Ethikrat 2012a-fr: 118-183, Moron-Puech 2011, Agius/Tobler 2011). Only certain aspects will be discussed here.

199. We can begin by highlighting the excellent example provided by the Australian law entitled the Sex Discrimination Amendment (Sexual Orientation, Gender Identity and Intersex Status) Act 2013 (Parliament of Australia 2013), which expressly extends protection from discrimination to encompass discrimination on the grounds of sexual orientation, gender identity and intersex status.

200. Secondly, in 2013, Germany adopted a law amending the civil-status law (Deutscher Bundestag 2013). Under Article 22, paragraph 3, of this law, when neither the female nor the male gender can be assigned to a child, the child must be entered in the register of births without any such specification. The result of this is that three options are now available when registering a birth: the child can be declared as female or male, or the relevant field can be left blank. Where a child cannot be assigned either the male or the female gender, the parents are required to leave the field in which they declare the child's gender blank and the law leaves them no choice in this.
201. Several intersex organisations have expressed their concerns regarding the law (OII Australia 2013a, OII Europe 2013, French-speaking OII 2013, Meister 2013, Vilorio 2013, zwischen-geschlecht.org 2013). The law does not deal with the main problem, namely stopping hormone treatment and surgery on children without their consent. On the other hand, it does force parents to reveal that they have an intersex child. The fear of the organisations is that, in order to avoid the stigmatisation liable to arise when the field specifying the child's gender is left blank, most parents will choose to have surgery performed at an early age (or abortion or prenatal "treatments"). Some foreign experiences show that adding a third option to birth registration documents is not enough in itself to stop normalisation procedures (OII Australia 2013a). Nor does the law include any measures to raise awareness about the existence of intersex children or to combat the discrimination to which they are exposed.
202. Although the law amounts to an initial recognition of the existence of intersex children at birth, it relates only to the declaration of the child's gender to the birth registration office (it does not create a "third gender") and this means that its scope is limited. In order for the right of intersex children to physical integrity to be protected, an additional piece of legislation is required.
203. At all events, the most important thing is to ensure that the requirement to declare the child's gender to the birth registration office (which is not a requirement under the UNCRC) does not amount to a circumstance which gives rise to decisions to have normalising surgery and hormone treatment performed on intersex children.
204. Furthermore, rapid and simple procedures should be set up to be able to change the registered gender when the wrong gender has been assigned to children or their intersex variation has emerged over the years following their birth. One option would be to leave the gender field blank up to a given age for all children.
205. Lastly, a public debate is needed to establish to what extent persons not identifying with the male or female gender categories might enjoy legal and social recognition.

4.6. Research

206. Studies should be carried out on the psychosocial situation of intersex children to make the best possible assessment of their needs and implement their rights.
207. At present, if people taking part in research state a gender other than male or female, they are automatically excluded. All research should provide for more than two gender options.
208. With regard to research on intersex people themselves, there is a methodological problem which should be highlighted. Given that a large number of people do not know that they may be considered intersex because of the incomplete information given to them by doctors, it is difficult to establish contact with them (Creighton/Liao 2004). Recruitment outside the medical

sphere is essential, not only for this reason but also because some intersex people are not the subject of any medical supervision linked to their intersex variation.

209. There is also a need to take stock of the normalising surgery and hormone treatment being carried out in Europe and its long-term effects. Such studies should be centred on the perception of their treatment by the persons concerned and not just on that of their doctors.

210. Because of the lack of widespread knowledge on the subject, it is imperative that such studies:

- adopt a participatory approach involving intersex organisations with long experience in the field;
- be independent from the medical community so as to guarantee that the information collected is not biased;
- be devised outside the gender dichotomy framework as, otherwise, intersex children could effectively be excluded from them or there is a risk that their situation will not be properly reflected.

4.7. Conclusion

211. The pressure of gender norms plays a major role where it comes to the contested medical procedures and also influences the social and legal situation of intersex children. In reality, gender norms give rise to violations of intersex children's rights at several levels and this prompts us to consider the need for a change of paradigm.

212. Bastien-Charlebois (in press) calls for the emphasis to be placed on the beauty of intersex lives

213. If this approach were adopted in the medical sphere, it would make it possible to welcome children as they are and provide them with protection. On a more general level, it would help intersex children to be given a place in our society.

4.8. Recommendations

Health system

214. Give complete priority to stopping so-called "normalising" surgery and hormone treatment on intersex children who are not able to give their consent. For this purpose:

- Actively promote the implementation of paragraph 7.5.3 of Resolution 1952 (2013) of the Parliamentary Assembly of the Council of Europe on children's right to physical integrity.
- Promote the adoption of national regulations expressly prohibiting so-called "normalising" surgery and hormone treatment for intersex children who are not able to give their informed consent. These national regulations should also establish the principle of children's physical integrity and clearly and exhaustively list cases in which exceptions can be made, namely those in which the child's life is in danger or the purpose is to prevent serious damage to the child's physical health. In addition, they should lay down the rule that children must be systematically informed of their situation, as appropriate for their age.

215. Promote training and information activities for health professionals on medical support for intersex children and, in particular:

- Foster a change in the medical approach to intersex variation by ensuring that during their initial and in-service training, health professionals are informed about intersex variation in a positive and non-pathologising light.
- Ensure that medical professionals doing work linked with childbirth are trained in announcing intersex variation in a positive manner.
- Support the organisation of multidisciplinary conferences to inform the medical professions about the ethical issues precluding the disputed types of surgery and hormone treatment.
- Raise the medical professions' awareness about the ethical principles governing the examination of intersex children's genitalia.

Vulnerable group

216. Promote the dignity of and respect for intersex children in all areas of their lives.

217. Treat intersex children as a vulnerable group requiring special protection.

218. Put an end to the inhuman and degrading treatment suffered by intersex children, especially in the health system, pursuant to states' obligations under the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment.

219. Promote a structured dialogue with groups and organisations representing intersex children and their parents in order to develop policies relating to them, placing the emphasis on children's physical integrity and their right to be heard.

220. Take into account the specific needs of intersex children when developing child welfare policies, which should be cross-sectoral in nature.

221. Treat intersex children as a high-risk group for suicide and include them in suicide prevention programmes.

222. Incorporate in initial and in-service training for professionals working with children information about intersex children, taking care to ensure that intersex variation is presented in a positive and non-pathologising way. This applies not only to staff in the welfare, education and health sectors but also to legal experts working in these fields.

Support for parenting and for intersex children

223. Develop counselling services, independent from the medical community, designed to help intersex children to grow up in a society structured around gender dichotomy and help parents to raise their children in such a society. The counselling should be based on the principle of unconditional acceptance of intersex children as they are, on the supply of information on the ethical and legal aspects of corrective medical procedures and on preventing the psychosocial risks to which the children and their families are exposed. The counselling should be designed in co-operation with representatives of intersex children and should be adequately funded.

Education system

224. Provide information on the existence of intersex people from childhood onwards by means of school curricula. For this purpose revise school curricula and books in all subjects so that they

portray intersex children and adults in a positive, non-pathologising way, particularly, but not solely, in biology lessons.

225. Provide teaching and childcare staff with initial and in-service training on how to deal with intersex children and their parents and on protecting children's privacy and safety.
226. Promote the development of guidelines on how to deal with intersex children in all institutions catering for children, with particular emphasis on protecting the privacy and safety of intersex children.
227. Promote, in all institutions catering for children, respect for gender expressions that do not conform to gender norms and respect for intersex children whose bodies are different from what is regarded as the norm.

Research

228. Carry out participatory research on the medical state of intersex children and adults. Such research should be devised and evaluated outside the medical community and relate in particular to the impact on psychological and mental health of normalising surgery and hormone treatment and the practices adopted when examining intersex children's genitalia.
229. Carry out participatory research on the social status of intersex children. Such research should be designed in such a way as to include more than two gender categories.
230. Provide for more than two gender options in any research involving children and adults.

Appendices

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Glossary

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| Gender assignment | Assignment of a gender to a baby on the basis of anatomical features regarded as “female” or “male”, in a societal system built around gender dichotomy. |
| Self-harm | A form of behaviour consisting in inflicting wounds or physical harm upon oneself, for example by cutting, burning, scratching, hitting or biting oneself or pulling out one’s hair. Self-harm is not carried out in itself with the intention of committing suicide but a large proportion of people who self-harm are also suicidal. The wounds are a physical manifestation of emotional pain. |
| Biphobia | Hatred, fear or disgust of bisexuality or bisexuals ²⁸ . |
| UNCRC | United Nations Convention on the Rights of the Child |
| DSD | Initials originally standing for “Disorders of Sex Development”, a medical description of certain types of variations of sex characteristics regarded by doctors as pathologies. Given that the pathological nature of variations in sex development is contested and considered to be stigmatising for the persons concerned, DSD is sometimes taken to stand for “Differences of Sex Development”. |
| Gender expression | A series of signs, visible to others, associated with belonging to a given gender (female, male or other, as defined by the individual concerned). This might include, for example, the way a person dresses, speaks and behaves. The concept serves to distinguish how a person feels about their gender identity from what they demonstrate through their outward appearance. |
| FtM or FTM | Abbreviation of “female-to-male”. A trans person assigned the female gender at birth who is making (or has made) a transition to a male social role with or without the corresponding bodily changes. NB.: Such persons should, in principle, be addressed as “he”, except if they expressly state otherwise. |
| Gonadectomy | Removal of the gland or glands which produce gametes (ovaries, testicles, ovotestes) and so-called female or male hormones ²⁹ . |
| Homophobia | Any manifestation, whether acknowledged or not, of discrimination, exclusion or violence vis-à-vis individuals, groups or practices referred to as homosexual ³⁰ . |
| Homosexual | Homosexual persons are those who feel a deep-lying emotional, affective and sexual attraction to individuals of “the same gender” and have intimate sexual relations with these individuals ³¹ . |
| Iatrogenic | Caused by doctors or medical treatment. |
| Gender identity | One’s private sense of being a man, woman or other individually defined gender, whether or not that corresponds to the gender assigned at birth. The Yogyakarta Principles define gender identity as referring to “each person’s deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth, including the personal sense of the body (which may involve, if freely chosen, modifications of bodily appearance or function by medical, surgical or other means) and other expressions of gender, including dress, speech and mannerism” ³² . |
| Interphobia | Fear of or irrational aversion to intersex persons because their anatomical states do not fall into standard “female” or “male” categories. |
| Intersex (or intersexed) | Describes a person whose sex characteristics are atypical or at variance with commonly accepted norms. |
| Intersex variation | A range of anatomical states which do not fall into standard “male” and “female” categories and can result from chromosomal, hormonal, gonadic or genital variations. Intersex variation can mean having one ovary and one testicle or gonads which |

²⁸ For a description in French see: *C’est comme ça : Pour les lesbiennes, gays, bi, trans et curieux...* URL: <http://www.cestcomme.ca/definition-biphobie.php> [15.11.2013].

²⁹ Quevauvilliers, J., Somogyi, A., Fingerhut, A. (2009): Dictionnaire Médical. 6th edition. Issy-les-Moulineaux: Elsevier Masson.

³⁰ URL: <http://www.egalitedeschancesbruxelles.irisnet.be/fr/lgbt/lutte-contre-lhomophobie/qu-est-ce-que-lhomophobie/> [22.11.2013].

³¹ URL: <http://www.egalitedeschancesbruxelles.irisnet.be/fr/lgbt/lutte-contre-lhomophobie/qu-est-ce-que-lhomophobie/> [15.11.2013].

³² *Yogyakarta Principles*, p. 6. URL : <http://www.yogyakartaprinciples.org> [15.11.2013].

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| | <p>contain both ovarian and testicular tissue (ovotestes).</p> <p>⇒The chromosome patterns XXY or XO instead of XX or XY are also intersex.</p> <p>⇒The genitalia of some – but not all – intersex people cannot be clearly identified as male or female.</p> <p>⇒Intersex variation can appear before birth, at birth or later, particularly at puberty or if the person concerned wants a child.</p> <p>Intersex variation is not itself a medical condition. It is more accurate to regard it as a label used to describe biological variety.³³</p> |
| LGB | <p>Initials standing for lesbian, gay and bisexual. Often the letter “T” is added for trans and sometimes “I” for intersex and/or even more rarely “Q” for queer or questioning.³⁴</p> |
| MtF or MTF | <p>Abbreviation of male-to-female (MtF). A trans person assigned the male gender at birth who is making (or has made) a transition to a female social role with or without the corresponding bodily changes.</p> <p>NB.: Such persons should, in principle, be addressed as “she”, except if they expressly state otherwise.</p> |
| Normal | <p>Maslow³⁵ has identified four distinct uses of the term normal:</p> <p>1) The term “normal” is sometimes used as a synonym for “statistically average”. A shift in meaning occurs when what falls within the realm of a statistical average is presented as “desirable” and anything else is considered pathological. According to Maslow, “we should learn to say average when we mean average”.</p> <p>2) “The word ‘normal’ is often used subconsciously as a synonym for ‘traditional’, ‘usual’ or ‘conventional’ and generally serves to advocate tradition.”</p> <p>3) When the term “normal” is applied in the context of cultural norms (principles decreed by culture to establish what is normal, desirable, good or healthy), it is obsolete because anthropology has shown that cultural norms did not have an absolute value for all cultures.</p> <p>4) “In the medical and clinical field, which is governed by a completely different tradition, the term ‘normal’ applies to the lack of manifest injury, illness or dysfunction”.</p> |
| Normalisation | <p>In the medical field,³⁶ this means:</p> <ol style="list-style-type: none"> 1. The restoration of or return to a normal state. 2. The establishment of norms or yardsticks with the aim of standardising certain concepts, products or substances. <p>N.B.: The definition of the term “normal” above highlights that what is considered “normal” is not universal but depends on factors such as contexts, viewpoints, and geographical locations.</p> |
| Gendernormativity | <p>Practices and institutions that legitimise and privilege those who live in the gender they were assigned at birth. Gendernormativity has a negative impact on intersex and trans people, people who do not identify with a gender, men who are perceived to be more “feminine” than is socially accepted, and women who are perceived to be too “masculine”.³⁷</p> |
| Gender norms | <p>The set of rules that are perceived to be binding as regards ways of feeling, behaving, dressing, etc. according to gender.</p> |
| Trans | <p>Abbreviation used in this report to designate children whose self-perception of gender, gender identity and/or gender expression differs from the gender assigned to them at birth. The exact content of this concept varies from author to author but at all events, it covers a wide range of sub-categories.</p> |
| Trans identity | <p>Term devised to contrast with that of “transsexuality” to emphasise that the issue here is identity, not sexuality, and which means possessing a gender identity which does not match the gender assigned at birth and the social expectations associated with that gender.</p> |

³³ RADELUX II (2012: 58), see “References”.

³⁴ URL: <http://en.wikipedia.org/wiki/LGBT>.

³⁵ Maslow, A. (2008): Devenir le meilleur de soi-même. Besoins fondamentaux, motivation et personnalité. Eyrolles, 188-189.

³⁶ Quevauvilliers, J., Somogyi, A., Fingerhut, A. (2009): Dictionnaire Médical. 6th edition. Issy-les-Moulineaux : Elsevier Masson.

³⁷ Definition based on: http://www.ilga-europe.org/home/publications/ilga_europe_glossary [15.11.2013].

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| Transition | A process of social (and often but not necessarily bodily) change by which persons abandon the gender roles corresponding to their assigned gender to adopt the gender role of another gender. |
| Transphobia | Irrational fear of persons because they express a gender identity or a social gender role other than the one assigned to them at birth, for example through behaviour which does not comply with the assigned binary social gender role, or through hormone treatment, surgery, clothes or cosmetics. Transphobia can manifest itself in the form of physical violence (insults, assault, rape or murder) or by discriminatory or intolerant behaviour (discrimination in recruitment, housing or access to medical treatment). ³⁸ |

³⁸ URL: <http://www.egalitedeschancesbruxelles.irisnet.be/fr/lgbt/lutte-contre-lhomophobie/quest-ce-que-la-transphobie/> [22.11.2013].

Argentinian law establishing the right to gender identity

(Unofficial translation by Alejandra Sardá – Chandiramani and Radhika Chandiramani; Translingua- Traducciones feministas multigenéricas (translingua_tfm@gmail.com)/GATE.)

Gender Identity Law - Buenos Aires, November 30th

Article 1 – Right to gender identity. All persons have the right,

- a) To the recognition of their gender identity;
- b) To the free development of their person according to their gender identity;
- c) To be treated according to their gender identity and, particularly, to be identified in that way in the documents proving their identity in terms of the first name/s, image and sex recorded there.

Article 2 – Definition. Gender identity is understood as the internal and individual way in which gender is perceived by persons, that can correspond or not to the gender assigned at birth, including the personal experience of the body. This can involve modifying bodily appearance or functions through pharmacological, surgical or other means, provided it is freely chosen. It also includes other expressions of gender such as dress, ways of speaking and gestures.

Article 3 – Exercise. All persons can request that the recorded sex be amended, along with the changes in first name and image, whenever they do not agree with the self-perceived gender identity.

Article 4 – Requirements. All persons requesting that their recorded sex be amended and their first name and images changed invoking the current law, must comply with the following requirements:

1. Prove that they have reached the minimum age of eighteen (18) years, with the exception established in Article 5 of the current law.
2. To submit to the National Bureau of Vital Statistics or their corresponding district offices, a request stating that they fall under the protection of the current law and requesting the amendment of their birth certificate in the records and a new national identity card, with the same number as the original one.
3. To provide the new first name with which they want to be registered.

In no case will it be needed to prove that a surgical procedure for total or partial genital reassignment, hormonal therapies or any other psychological or medical treatment has taken place.

Article 5 – Minors. In relation to those persons younger than eighteen (18) years old, the request for the procedure detailed in Article 4 must be made through their legal representatives and with explicit agreement by the minor, taking into account the evolving capacities and best interests of the child as expressed in the Convention on the Right of the Child and in Law 26061 for the Comprehensive Protection of the Rights of Girls, Boys and Adolescents. Likewise, the minor must be assisted by a children's lawyer as prescribed by Article 27 of Law 26061.

When the consent of any of the minor's legal representatives is denied or impossible to be obtained, it will be possible to resort to summary proceedings so the corresponding judges will decide, taking into account the evolving capacities and best interests of the child as expressed in the Convention on the Right of the Child and in Law 26061 for the Comprehensive Protection of the Rights of Girls, Boys and Adolescents.

Article 6 – Procedure. Once the requirements stated in Articles 4 and 5 are met, the public officer will proceed – without any additional legal or administrative procedure required - to notify the amendment of the sex and the change of first name to the Civil Register corresponding to the jurisdiction where the birth certificate was filed so it will issue a new birth certificate incorporating the said changes, and to issue a new national identity card reflecting the amended sex and the new first name as now recorded. Any reference to the current law in the amended birth certificate and in the new national identity document issued as a result of it is forbidden.

The procedures for amending the records as described in the current law are free, personal and do not require the intervention of any agent or lawyer.

Article 7 – Effects. The effects of the amendment of the sex and recording a new first name/s according to the current law will create rights against third parties since the record is first made.

The amendment in the records will not change the legal entitlements to rights and legal obligations that could have corresponded to the persons before the recording of the amendments, nor those derived from the relationships consecrated by family law at all levels and degrees, that will remain unchanged, including adoption.

In all cases, the number in the persons' national identity document will be relevant over the first name or morphological appearance of the persons, for identification purposes.

Article 8 – The record amendments prescribed by the current law, once completed, can only be modified again with judicial authorization.

Article 9 – Confidentiality. Only those authorized by the document holder or provided with a written and well-founded judicial authorization can have access to the original birth certificate.

The amendment of the recorded sex and the change in first name will never be given to publicity, except with the authorization of the document holder. The publication in newspapers prescribed by Article 17 of the Law 18248 will be omitted in these cases.

Article 10 – Notifications. The National Bureau of Vital Statistics will provide information about the change of national identity document to the National Registry of Criminal Records, to the corresponding Electoral Registry for correction of electoral rolls and to other bodies as determined in the regulation of this law, including those that might have information on existing precautionary measures involving the interested party.

Article 11 – Right to free personal development. All persons older than eighteen (18) years, according to Article 1 of the current law and with the aim of ensuring the holistic enjoyment of their health, will be able to access total and partial surgical interventions and/or comprehensive hormonal treatments to adjust their bodies, including their genitalia, to their self-perceived gender identity, without requiring any judicial or administrative authorization.

There will be no need to prove the will to have a total or partial reassignment surgery in order to access comprehensive hormonal treatment. The only requirement will be, in both cases, informed consent by the individual concerned. In the case of minors, the informed consent will be obtained following the principles and requirements established in Article 5. Without prejudice to the former, when consent for total or partial surgical intervention is to be obtained, the competent judicial authorities for the jurisdiction must also express their agreement, taking into account the evolving capacities and best interests of the child as expressed in the Convention on the Right of the Child and in Law 26061 for the Comprehensive Protection of the Rights of Girls, Boys and Adolescents. Judicial authorities must express their views within sixty (60) days from the time they were required to provide their agreement.

Public health officials, be they from the state, private or trade union-run health insurance systems, must guarantee in an ongoing way the rights recognized by this law. All medical procedures contemplated in this article are included in the Compulsory Medical Plan (that is, they are not subjected to additional costs for those having private or trade union-run insurance plans), or in whatever system replaces it, as decided by the enforcing authority.

Article 12 – Dignified treatment. The gender identity adopted by the individual must be respected, particularly in the case of girls, boys and adolescents using a first name that is different from the one recorded in their national identity documents. Whenever requested by the individual, the adopted first name must be used for summoning, recording, filing, calling and any other procedure or service in public and private spaces.

When the nature of the procedure makes it necessary to register information in the national identity document, a system will be employed that combines the initials of the first name, the surname in full, date and year of birth, and the number of the document, adding the first name chosen by the individuals on the ground of their gender identity if so required by them.

In those circumstances in which the person must be named in public, only the chosen first name respecting the adopted gender identity will be used.

Article 13 – Enforcement. Every norm, regulation or procedure must respect the human right to gender identity. No norm, regulation or procedure must limit, restrict, exclude or annul the exercise of the right to gender identity, and all norms must always be interpreted and enforced in a manner that favors access to this right.

Article 14 – Section 4 of Article 19 in Law 17132 is repealed. (This 1967 law regulates the practice of Medicine, Dentistry and their auxiliary professions. The repealed section forbade doctors to carry on “surgical interventions modifying the sex of the sick person, unless they are performed after judicial authorization has been provided.”)

Article 15 – The passing of this law is to be communicated to the Executive Power.