

Gender-Affirming Treatments to Children with Gender Dysphoria: Balancing the Children's Constitutional Rights

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Abstract

Gender dysphoria occurs not only in adults but also in underage children. Their inner conviction that their gender identity does not align with their physical body leads to a desire to alter their physical appearance through gender-affirming treatment(s) that affirm their gender identity. Examples include genitoplasty, puberty blockers, and cross-sex hormone therapies. Proponents argue that these desires should be accommodated because everyone, including children, has the right to determine what can be done to their own bodies. Moreover, some findings suggest that such treatments can have positive psychological benefits for these children. On the other hand, opponents question whether the consent given by children who desire such treatments is legitimate. Additionally, providing irreversible medical treatments solely to affirm gender identity can have physiological and psychological impacts. Thus, instead of affirming the desires of these children, medical physicians should focus on saving them from irreversible medical actions. This discourse is conducted by considering proportionally the constitutional rights of children, which need to be balanced with ensuring their knowledge and maturity in making decisions.

Keywords: *children, gender dysphoria, gender-affirming treatments, constitutional rights*

I. INTRODUCTION

This article focuses on the reality of individuals who experience a disconnect between their gender identity and their physical bodies. It is called “gender dysphoria.” These feelings are often followed by medical interventions, known as gender-affirming treatments (GAT), which can include genital surgery (genitoplasty), puberty blockers, and cross-sex hormone therapy.¹

Currently, there is a growing number of transgender and non-binary individuals among children, especially those under 18 years old. While there is no global survey that has quantified the number of transgender and non-binary children, some countries like the United States and the United Kingdom have seen a significant increase in cases. A study conducted by the National Health Service in the UK in 2021 revealed that over 5,000 children expressed a desire to change their gender, compared to just 250 cases a decade earlier.² Similarly, in the United States, Reuters and Komodo Health Inc. found that in October 2021, there were 42,167 children with gender dysphoria, a sharp increase from approximately 15,172 cases in 2017.³ It is worth noting that these numbers are likely lower than the actual figures, as they only account for cases covered by health insurance.⁴

Regarding Indonesia, precise studies quantifying the number of gender dysphoric children who have or have not undergone medical interventions to affirm their gender identity are scarce. However, fragmented research findings suggest that this reality exists in Indonesia and has the potential to increase.⁵ Notably, there is a significant population of individuals who have transitioned and a growing LGBTQIA+ community. In 2015 alone, the number of transgender individuals in Indonesia approached 500,000.⁶ Additionally, campaigns regarding transgender youth are becoming more accessible through mass media, including cartoons that children can watch.

This reality has sparked debates. Those in favor argue that children should be allowed the freedom to explore and determine their gender identity when experiencing

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- 1 Christina Prediger, *et. al.*, “LGBTQIA+ Adolescents’ Perceptions of Gender Tailoring and Portrayal in a Virtual-Reality-Based Alcohol-Prevention Tool: A Qualitative Interview Study and Thematic Analysis,” (2023) 20:2784 *International Journal of Environmental Research and Public Health* 1-20.
 - 2 National Health Service England. NHS commissioning: Implementing advice from the Cass Review. Available on at <https://www.england.nhs.uk/commissioning/spec-services/npc-crg/gender-dysphoria-clinical-programme/implementing-advice-from-the-cass-review/>. Accessed on 19 September 2023.
 - 3 Komodo Health. Komodo Findings Point to Rising Healthcare Needs for Transgender Youth. Available online at <https://www.komodohealth.com/insights/komodo-findings-point-to-rising-healthcare-needs-for-transgender-youth>. Accessed on 31 August 2023.
 - 4 Fitriyan Zamzani. Mengejutkan, Terjadi Ledakan Transgender Anak di Barat. Available online at <https://news.republika.co.id/berita/rlzrqt393/mengejutkan-terjadi-ledakan-transgender-anak-di-barat>. Accessed on 31 August 2023.
 - 5 Kementerian Pemberdayaan Perempuan dan Perlindungan Anak dan Pusat Penelitian Kesehatan Universitas Indonesia, “Laporan Kajian: Pandangan Lesbian, Gay dan Biseksual terhadap Status gender dan Persamaan Hak Asasi Manusia di Jakarta, Bogor, Depok, dan Tangerang,” (2015), 2.
 - 6 Aprilina Pawestri, “Politik Hukum Negara terhadap Gerakan Lesbian, Gay, Biseksual, dan Transgender” (Surabaya: Scopindo Media Pustaka, 2015).

gender dysphoria.⁷ They view it as a child's right to decide what is best for them and believe that there is no harm to others or other children.⁸ The state is seen as having a role in protecting these rights and providing healthcare services to accommodate the needs of these children rather than obstructing or punishing them.

On the other hand, some question the legitimacy of consent given by children for medical interventions.⁹ They argue that such explorations and decisions should involve experts and parents to make informed and rational choices, especially given that medical gender-affirming treatments are irreversible and have long-term medical implications. Moreover, in the context of Indonesia, this reality is seen as conflicting with the prevailing social and religious values of gratitude for the physical bodies bestowed by a higher power.

A normative and solution-oriented discussion of this issue is urgently needed. The development of gender dysphoric children is no longer an individual matter but a societal one, as children are the future assets of the nation.¹⁰ In this context, clarity is needed regarding the normative status quo: how should the state regulate gender dysphoric children who wish to consent to GAT? There are pros and cons, but even in the face of challenges, a constructive and solution-focused approach is necessary, rather than simply distancing or banning this community. Moreover, is it appropriate to affirm every wish of a child without providing alternative perspectives, especially when those wishes have long-term and irreversible consequences? It is hoped that this discussion can provide solutions to the issues that have arisen.

To our knowledge, there is no normative discussion that specifically addresses the reality of gender dysphoric children undergoing GAT. Most normative insights come from foreign references, given the longstanding discourse in those regions, as evidenced by the various references cited in this article. However, this article requires additional knowledge from fields such as medicine and psychology to dissect the reality of GAT for a more accurate normative analysis.

This article consists of three main sections. First, it elaborates on several concepts, including gender dysphoria, children compared to adults, the distinction between rights and freedoms in a healthcare context, and GAT, which focuses on genitoplasty, puberty blockers, and hormone therapy. Second, it explains the normative status quo regarding gender dysphoric children seeking GAT, covering genitoplasty, puberty blockers, and hormone therapy, with a focus on the rights of children, the role of doctors, and GAT itself. Last but not least, it presents an analysis and evaluation of the current status quo to determine whether there is a strong legal justification for state intervention in this issue.

7 Julia Temple Newhook, *et. al.*, "Teach your parents and providers well: Call for refocus on the health of trans and gender-diverse children," (2018) 64 *Canadian Family Physician* 332-335.

8 *Ibid.*

9 Bernadeta Resti Nurhayati and Hartyo Purwanto, "Kajian Terhadap Pemenuhan Hak Asasi Manusia Anak dalam Pelaksanaan Informed Consent Pasien Anak," (2022) 3:2 *Jurnal Pacta Sunt Servanda* 160.

10 *Ibid.*, 161.

II. DESCRIBING THE CONCEPTS

1. Gender and Gender Dysphoria

First and foremost, an understanding of gender needs to be presented to differentiate it from biological sex, often referred to as "sex" in terms of physiological characteristics.¹¹ Sex, in a physiological context, can be distinguished by the physical differences between males and females, such as genitalia, chromosomes, muscle mass, voice tone, and facial features.¹² For example, females have vaginas, while males have penises.¹³

On the other hand, gender is about how individuals, whether male or female, behave, both in an individual and social context, but it is also associated with their physiological characteristics.¹⁴ This distinction is often used to determine status, rights, roles, functions, and social interactions based on gender.¹⁵ In general, the gender forms that arise from the differences between males and females are men and women. These social roles can be learned, change over time, and vary between and within cultures.¹⁶

The context of the above understanding needs to be applied to define gender dysphoria. Etymologically, dysphoria comes from the Greek word "dysphoros/δύσφορος," which means "hard to bear."¹⁷ This difficulty, in the context of gender dysphoria, takes the form of an inability to accept that there is a mismatch between one's current physiological characteristics and the gender one identifies with, leading the individual to desire a gender transition, whether from male to female or vice versa.¹⁸ This mismatch can be caused by various factors, such as genetics, hormones, and environment.¹⁹ Essentially, gender dysphoria is a psychological condition, not a medical or physiological condition like cancer or heart disease, where there is a dysfunction of physiological organs.

Experiencing gender dysphoria is undoubtedly not easy, as it can result in various consequences for individuals, both psychologically and socially. In some cases, gender dysphoria co-occurs with other psychological conditions, such as autism, depression,

11 Hilary M. Lips, "Sex and Gender" (America: Waveland Press Inc, 2020), 93.

12 *Ibid.*

13 *Ibid.*, 224.

14 Ade Kartini and Asep Maulana, "Redefenisi Gender dan Seks," (2019) 12:2 *Jurnal Kajian Perempuan dan Keislaman* 221.

15 *Ibid.*, 222.

16 *Ibid.*

17 Patrizia Moretti, *et. al.*, "Dysphoria as a Psychiatric Syndrome: A Preliminary Study for a New Transnosographic Dimensional Approach," (2018) 30:Suppl7 *Psychiatria Danubina* 582.

18 Hedi Claahsen, *et al.*, "Gender Incongruence and Gender Dysphoria in Childhood and Adolescence—Current Insights in Diagnostics, Management, and Follow Up," (2021) 180:5 *European Journal of Pediatrics* 1350.

19 *Ibid.*

anxiety disorders, trauma, et cetera.²⁰ This can happen because individuals with gender dysphoria often face mistreatment because of their dysphoria. In one study, it was found that about 56% of individuals experiencing gender dysphoria had experienced at least four different traumatic events.²¹ As a result, many individuals have low self-esteem and diminished life goals.

2. Children and Their Differences from Adults

In the Indonesian Civil Code (KUHPer), someone is considered an adult when they reach the age of 21 or older.²² However, this provision is not the sole regulation governing the age of adulthood. According to Article 47 of Law Number 1 of 1974, a child is defined as someone who has not yet reached the age of 18.²³ Additionally, under Article 63 of Law Number 24 of 2013 on Population Administration Changes to Law Number 23 of 2006, Indonesian citizens (WNI) who are 17 years old are required to possess an Identity Card (KTP).²⁴ This implies that someone who is 17 years old is considered an adult, while in the Guidelines for Ethics and Professional Behavior of Indonesian Pediatric Specialists (PEP-DSAI), a child is defined as someone under 18 years old.²⁵ Thus, it can be observed that the criteria for adulthood differ among various regulations, but the age range typically falls between 17-21 years.

Certainly, there are legal consequences that differ between children and adults. The first difference in legal consequences relates to their legal capacity to perform legal actions. Legal capacity means having the cognitive ability to understand, analyze, and evaluate the legal consequences of their actions and being able to be held responsible for them.²⁶ Legally, only adults are considered competent or allowed to perform legal actions, whereas a child wishing to undertake a legal action must have a guardian, such as a parent, as they are deemed incapable of performing legal actions.²⁷

For example, a legal agreement, such as a sales contract, is only valid if entered into by an adult. This aligns with Article 1320 of KUHPer, which states that one of the

20 Kasia Kozłowska, *et. al.*, "Australian children and adolescents with gender dysphoria: Clinical presentations and challenges experienced by a multidisciplinary team and gender service," (2021) 1:1 *Human Systems: Therapy, Culture and Attachments* 72.

21 Kate Cooper, *et al.*, "The phenomenology of gender dysphoria in adults: A systematic review and meta-synthesis," (2020) 80:101875 *Clinical Psychology Review* 4.

22 Indonesia, *Kitab Undang-Undang Hukum Perdata*, Art. 330.

23 Indonesia, *Undang-Undang Perkawinan*, UU No.1 Tahun 1974, LN. 1974/ No.1, TLN No. 3019, Art. 47.

24 Indonesia, *Undang-Undang Perubahan atas Undang-Undang Nomor 23 Tahun 2006 tentang Administrasi Kependudukan*, UU No.24 Tahun 2013, LN. 2013/ No.232, TLN No. 5475, Art. 63.

25 Ikatan Dokter Anak Indonesia, "Panduan Etika dan Perilaku Profesi Dokter Spesialis Anak Indonesia," 2014. Available online at <https://www.idai.or.id/professional-resources/ethic/pep-dsai>

26 Sahat Maruli, "Pengantar Sistem Hukum Indonesia: Suatu Tinjauan Teoritis," (Bandung: Logoz Publishing, 2020), 17.

27 *Ibid.*

conditions for a valid agreement is that the parties involved must be competent to enter into an obligation.²⁸ If an incompetent party enters into a sales contract, the agreement can be voided. Therefore, a child requires a competent guardian to undertake legal action.

The second difference in legal consequences pertains to accountability. Those considered competent to perform legal actions are fully responsible for their legal deeds.²⁹ For example, an adult who commits a theft will be held fully accountable. In the context of children, there is a significant difference. In civil matters, children must be represented by their parents because they are considered incapable of managing their own affairs, while in criminal contexts, children will not be held fully accountable and will not be treated similarly to adults.

There are physiological and psychological differences between children and adults. What needs to be emphasized more is the psychological differences. Cognitively, children are still developing their ability to process information and understand the realities of the natural and social world around them. Consequently, adults generally possess more information, data, and tools to analyze information compared to children due to the exposure gap between the two groups.³⁰

The second aspect relates to emotions. Because of their early psychological development, children tend to have more difficulty controlling their emotions compared to adults.³¹ They are more susceptible to the dynamics of the world around them, affecting their emotional states. Additionally, children are still in the process of learning to understand others' emotional conditions or what others are feeling psychologically.³² Empathy tends to be more developed in adults. Furthermore, children are still searching for their identities; compared to adults, adults tend to be more emotionally stable due to their better emotional intelligence.³³

3. The Differences Between Rights and Freedom in Healthcare

An analysis of gender-affirming surgery in children should also begin with a precise definition of rights and freedoms in healthcare. This is because gender-affirming surgery is generally carried out through selective activities or obtaining medical procedures. In

28 Kitab Undang-Undang Hukum Perdata, *supra note 22*, Art. 1320.

29 Ruzaipah, Abdul Manan, dan Qurrota A'yun, "Penetapan Usia Kedewasaan Dalam Sistem Hukum Di Indonesia," (2021) 1:1 *Jurnal Misaqan Ghalizan* 16.

30 Christiana Hari, "Seri Psikologi Perkembangan: Perkembangan Anak Sejak Pembuahan Sampai dengan Kanak-kanak Akhir" (Jakarta: Kencana, 2018) 8.

31 *Ibid.*, 193.

32 Pamela M. Cole, *et.al.*, "From children's expressive control to emotion regulation: Looking back, looking ahead," 2018 15:6 *Eur J Dev Psychol* 658-677/. See also Natasha H. Balien, *et.al.*, "Understanding Emotion in Adolescents: A Review of Emotional Frequency, Intensity, and Clarity," (2019) 11:1 *Emotion Review* 63-73.

33 Hari, *supra note 30*, 193.

principle, rights and freedoms are closely related to choices of action. Rights pertain to something obtained with the involvement of external parties to fulfill them through choices of action. Meanwhile, freedom is related to the absence of external involvement to restrict, allowing the individual to freely make choices of action.

When considered from its definition, health encompasses not only physical well-being but also psychological aspects, as Law No. 17 of 2023 on Health (hereafter, “Health Law”) itself emphasizes that health is strongly linked with productivity.³⁴ Being productive is not merely about physical health but also psychological health. The scope of health fulfillment includes promotion, prevention, cure, rehabilitation, and palliative care.³⁵ Therefore, health is not only achieved when one is ill but also involves obtaining the necessary information to maintain one's well-being.

In the context of health freedom, freedom here is assumed first as the choices made to maintain one's health, both physically and psychologically, and not otherwise. Every individual is free to choose which hospital and which doctor they wish to consult to identify their medical issues and then request the appropriate prescription to address those medical issues. This freedom should not extend to intervening in a doctor's prescription or even forcing a doctor to take a specific medical action.³⁶ If the individual disagrees with the medical treatment prescribed by the doctor, they are welcome to seek a second opinion from another doctor.³⁷

4. Gender Affirming Treatment to Children: Puberty Blockers, Cross-Sex Hormone Therapy, and Genitoplasty

The advancement of innovations in the field of healthcare opens up opportunities for new discoveries. One of the innovations in healthcare is medical procedures oriented towards affirming the gender identity of individuals experiencing gender dysphoria. These methods come in various forms, such as puberty blockers, hormone replacement therapies, and genitoplasty.

The first type of Gender-Affirming Treatment (GAT) is puberty blockers (PB). Typically, in PB procedures, a doctor will administer a gonadotropin-releasing hormone antagonist (GnRHa) to the body of a child who wishes to transition gender. GnRHa suppresses the production of GnRH, which usually stimulates the production of sex hormones, leading to gonadal deficiency and delaying puberty.³⁸ The use of GnRHa is

34 Indonesia, *Undang-Undang Kesehatan*, UU No. 17 Tahun 2023, LN. 2023/No.105, TLN No. 6887, Art. 1.

35 *Ibid.*, Art. 18.

36 Basil Varkey, “Principles of Clinical Ethics and Their Application to Practice,” (2021) 30:1 *Medical Principles and Practice* 18. See also Zulhasmar dan Eric, “Implikasi Hukum Penolakan Tindakan Medik.” (2008) 5:2 *LexJuralica* 86.

37 *Ibid.*

38 Jacques Young, et.al., “Clinical Management of Congenital Hypogonadotropic Hypogonadisme,” (2019) 40:2 *Endocrine Reviews* 669.

more effective than regular GnRH because it usually serves as the initial stimulant in the hypothalamic-pituitary-gonadal axis, leading to increased secretion of follicle-stimulating hormone, luteinizing hormone, and gonadal hormones, followed by decreased pituitary-gonadal regulation.³⁹ In addition to GnRHa, there are other medications commonly used to delay puberty, but primarily for the treatment of precocious puberty, such as leuprolide acetate injections and histrelin acetate implants.⁴⁰

Another GAT aimed at complementing the use of puberty blockers is cross-sex hormone therapy. In this treatment, doctors administer hormones corresponding to the desired gender of the child.⁴¹ For a child assigned male at birth wishing to transition to female, this involves providing estrogen and anti-androgens to suppress testosterone production or testosterone supplementation.⁴² The use of estrogen and anti-androgens triggers breast development, reduces pubic hair growth and lean body mass, increases fat mass, widens hips, and clinically affects libido.⁴³ Conversely, testosterone supplementation for individuals biologically assigned female at birth increases lean body mass and muscle strength, thickens body hair, and deepens the voice.⁴⁴

Both PB and cross-sex hormone therapy share similarities in influencing the child's body by manipulating hormones. However, they have different roles in altering the hormonal cycle of the body. PB delays the production of sex hormones in the child's body, inhibiting puberty-related changes such as breast development, genital hair growth, body mass, and more. In contrast, hormone therapy promotes puberty in the child, and the child's physical growth will follow the effects of the hormones introduced into their body. These effects can include breast development in individuals assigned male at birth using estrogen⁴⁵ or increased body hair in individuals assigned female at birth using testosterone.⁴⁶ Yet, the suppression of menstruation is more effective when combined with the use of GnRHa.⁴⁷

39 Carly Guss and Catherine M. Gordon, "Pubertal Blockade and Subsequent Gender Affirming Therapy: True, True, and Unrelated?" (2022) 5:11 *Jama Network Open* 1.

40 Lopez CMD, et.al., "Trends in the use of Puberty Blockers among Transgender Children in the United States," (2017) 2:2 *Journal of Pediatric Endocrinology* 1-5.

41 Laurens D'hoore and Guy T'Sjoen, "Gender-affirming hormone therapy: An Updated literature review with eye on the future," (2022) 291:5 *Journal of Internal Medicine* 575.

42 Martin den Heijer, Alex Bakker, and Louis Gooren, "Long Term Hormonal Treatment for Transgender People," (2017) 359:j5027 *British Medical Journal*.

43 *Ibid.*

44 *Ibid.*

45 New breast growth becomes noticeable after 2-3 months of estrogen use and reaches its maximum after 2 years. However, sometimes the growth is not significant. Therefore, patients may enhance their breasts through surgery or breast implants. See: Christel Josefa Maria de Blok, et. al., "Breast Development in Transwomen After 1 Year of Cross-Sex Hormone Therapy: Results of a Prospective Multicenter Study," (2018) 103:2 *The Journal of Clinical Endocrinology & Metabolism* 532-538.

46 Leighton J Seal, "A review of the physical and metabolic effects of cross-sex hormonal therapy in the treatment of gender dysphoria," (2016) 53:1 *Annals of Clinical Biochemistry* 15.

47 *Ibid.*, 15.

Children wishing to transition gender are not required to immediately undergo both hormone therapies that affect hormones, as described above. They can choose to undergo one of them first. For example, the World Professional Association for Transgender Health Standards of Care recommends menstrual suppression for female children wishing to transition to male but who do not yet wish to undergo cross-sex hormone therapy.⁴⁸

The last method of GAT is genitoplasty. In the context of gender reassignment from male to female, this involves the removal of the penis (penectomy), testes (orchiectomy), and scrotal sac. The principle is to remove the penis as the urinary outlet, which is then replaced by creating an artificial vagina that includes the replication of the vulva, labia, clitoris, and urethra by modifying the removed penis tissue. Meanwhile, the procedure that changes gender from female to male is known as masculinizing genitoplasty. The formation of male genitalia is done through a four-stage procedure. The first two stages involve hysterectomy (removal of the uterus) and oophorectomy (removal of the ovaries). Subsequent procedures are metoidioplasty (creation of a new penis) and phalloplasty (formation of a penis).

III. THE STATUS QUO OF GENDER-AFFIRMING TREATMENT TO CHILDREN IN INDONESIA

To address how regulations regarding Gender-Affirming Treatment (GAT) for children are in Indonesia, three related variables need to be examined first from a positive legal perspective: children, doctors, and GAT. In the context of the child variable, the aspect discussed is the child's right to health, considering the realization and the extent to which the fulfillment of these boundaries can be achieved. Meanwhile, in the context of the doctor variable, the aspect observed is the norms that bind doctors when interpreting medical conditions and conducting medical procedures for a child experiencing gender dysphoria. Furthermore, the actions taken as methods to be applied by doctors to children are elaborated upon in terms of the applicable norms.

1. Children's Rights to Health

Everyone, including children, has the right to live a healthy life, both physically and mentally. In essence, everyone has the right to life and the preservation of life. One concrete form of preserving one's life is by maintaining the health of their body, including seeking healthcare services when one feels a need for professional medical assistance.⁴⁹ This right has even become a constitutional right as stipulated in Article 28H paragraph (1) of the Constitution of the Republic of Indonesia, Year 1945, which states that

48 Eli Coleman, *et. al*, "Standards of care for the health of transgender and gender diverse people," (2022) 23:Suppl 1 *Int.J Transgend Health* 2022 S1-S259.

49 Indonesia, *Undang-Undang Dasar 1945*, Art. 28A.

everyone has the right to obtain decent healthcare services provided by the state.⁵⁰ Specifically for children, Article 28B paragraph (2) states that every child has the right to survival, growth, and development.⁵¹

Furthermore, Indonesia has also ratified the Convention on the Rights of the Child held in 1989.⁵² One aspect of the Convention emphasizes that every child has the right to receive the highest standard of healthcare, the best medical treatment, and easy access to health-related information.⁵³ Countries are encouraged to make efforts aimed at preventing the violation of a child's right to access healthcare services.⁵⁴

At the national level, Law Number 35 of 2014 concerning Child Protection (UUPA) was also established to ensure that Indonesian children can grow and develop without experiencing discrimination in their environment. One of the aspects related to healthcare mandated in UUPA is the availability of comprehensive healthcare facilities and services for children.⁵⁵ This is a mandatory task to be carried out by the government, as well as the involvement of parents and the surrounding community in protecting the child's right to healthcare. In fact, parents are the key figures who give consent to doctors to perform medical procedures on their children.⁵⁶

2. The Position and Ethics of Doctors in Medical Procedures to Children

Doctors play a key role when applying gender-affirming treatment (GAT) to children. Regarding the doctor's position in the context of their relationship with patients, the fundamental question is, what is the relationship between a doctor and a patient?

In establishing the relationship between a doctor and a patient, every doctor in Indonesia is bound by the Indonesian Code of Medical Ethics (Kodeki) after taking the oath as a doctor.⁵⁷ There are four main pillars of medical ethics, whose applicability can be seen in the preamble of Kodeki as internationally recognized pillars.⁵⁸ Additionally, there are various ethical and practical guidelines related to specialized medical fields, such as the Guidelines for Ethics and Behavior of the Profession of Pediatric Specialists

⁵⁰ *Ibid.*, Art 34.

⁵¹ *Ibid.*, Art. 28B.

⁵² Indonesia, *Keputusan Presiden tentang Pengesahan Convention on the Rights of the Child*, Keppres No. 36 Tahun 1990.

⁵³ United Nations, *Convention on the Rights of the Child*, Art. 24.

⁵⁴ Neli Gradinarova, "Children's rights and access to health care," (2023) 2:1 *Medical Science and Research* 44.

⁵⁵ Indonesia, *Undang-Undang Perlindungan Anak*, UU No. 35 Tahun 2014, LN No. 297 Tahun 2014, TLN No. 5606, Art 44 ayat (1).

⁵⁶ This is explicitly stated in Article 20 of the PEP-DSAI. Doctors are required to obtain parental consent before performing medical procedures.

⁵⁷ Majelis Kehormatan Etik Kedokteran Indonesia, *Kode etik kedokteran Indonesia dan pedoman pelaksanaan kode etik kedokteran Indonesia* (2012), penjelasan Ps. 1, <http://mkekidi.id/wp-content/uploads/2016/01/KODEKI-Tahun-2012.pdf>.

⁵⁸ *Ibid.*, Mukadimah.

in Indonesia (PEP-DSAI). While the competence to perform GAT lies outside the realm of pediatric specialists, there are important principles to consider when a child is a patient.

The first principle is beneficence. This principle means that doctors and nurses are required to take action for the patient's benefit. Specifically, it involves providing and presenting available options, including both their positive and negative aspects. Explicitly, Article 14 of Kodeki obligates doctors, along with the analysis and medical interpretation of the patient's condition, to use all their knowledge and skills acquired during their higher education.⁵⁹ Article 4 of PEP-DSAI further emphasizes that a child must be treated by the doctor as if they were the doctor's own child.⁶⁰ Psychologically, this means the doctor must provide the best healthcare to the child and protect them from any harm or disability.

The second principle is non-maleficence, meaning that doctors must not intend to harm or cause suffering to a patient, either intentionally or unintentionally. Doctors should not administer medical treatments that have significant short-term or long-term adverse effects that are not medically sound and effective in resolving the patient's medical issues.⁶¹ In this context, doctors should not disregard scientific truths they have learned based on their personal views on social issues, as prohibited by Article 3 of Kodeki. For example, even if a doctor personally supports LGBTQIA+ rights, they should not ignore the long-term effects that medical treatment for a child with gender dysphoria may have.

This is also consistent with the principle of justice. Doctors must not differentiate their services among patients based on their personal biases. Pursuant to Article 2 in conjunction with Articles 23 and 28 of the Health Law, doctors must not discriminate in providing services based on religion, gender, race, ethnicity, nationality, skin color, physical condition, social status, social group, or even perspective preferences. For instance, a doctor who disagrees with LGBTQIA+ rights should not, based on their personal beliefs, provide subpar care to a child with gender dysphoria.

The last principle is respect for autonomy, which forms the basis of obtaining informed consent. This means that patients are considered capable individuals with the right to make decisions about their own bodies.⁶² In this principle, doctors are obligated to provide complete information about the medical treatment after conducting an analysis and medical interpretation of the patient's condition.⁶³ Subsequently, doctors must offer choices to the patient and leave the decision regarding medical treatment to

⁵⁹ *Ibid.*, Art. 14.

⁶⁰ Ikatan Dokter Anak Indonesia, *supra* note 25, art. 4.

⁶¹ Varkey, *supra* note 36, at 18-19.

⁶² A Tomson, "Gender-affirming care in the context of medical ethics -gatekeeping v. informed consent," (2018) 11:1 *South African Journal of Bioethics and Law*.

⁶³ Humas FKU UGM. "Otonomi vs Paternalisme: Mana yang Lebih Baik?" Available online at <https://fkkmk.ugm.ac.id/otonomi-vs-paternalisme-mana-yang-lebih-baik/>. Accessed August 28, 2023,

the patient without coercion or pressure. Therefore, it can be concluded that through the principle of autonomy, patients have the right to make decisions regarding their medical treatment.

Nevertheless, it is important to emphasize that the patient's autonomy is limited to approving or disapproving medical treatments that the doctor will provide. From the beginning, the patient cannot force or dictate the specific medical treatment to be administered. Additionally, Article 24 of PEP-DSAI states that a doctor can refuse and terminate a therapeutic relationship if the child and the parents request a medical treatment that is medically harmful based on the medical knowledge the doctor has acquired.⁶⁴ On the other hand, the child and the parents are free to choose another doctor.

3. Gender-Affirming Treatments to Children According to Positive Law in Indonesia

Based on our research of positive law, there is no explicit norm that regulates whether gender-affirming treatment (GAT) can or cannot be administered to children. The Health Law only regulates the procedure for reconstructive plastic surgery, as stipulated in Article 137 of the Health Law. Doctors are prohibited from performing reconstructive plastic surgery on the face, gender, or fingerprints when it is against the law.⁶⁵ However, the definition of "against the law" itself is not very clear when questions like "Does changing gender for reasons of gender dysphoria fall into the category of being against the law" are raised.

The limitations of existing positive law require an examination of the current legal status by referring to the Indonesian Code of Medical Ethics (Kodeki). First, Article 1 of Kodeki states that "every doctor must uphold, internalize, and practice the doctor's oath." In connection with this rule, there are clauses in the doctor's oath that can be considered by a doctor before performing GAT, which is the doctor's obligation to always prioritize the patient's health while considering the interests of society.⁶⁶ Before a doctor carries out GAT, the doctor must consider the patient's health, such as the various medical implications the patient will experience or the specific benefits the patient can receive after undergoing GAT.

At the same time, a doctor must also consider the interests of society. One aspect of this is the religious perception of Indonesian society regarding transgender reality.⁶⁷ However, a doctor must also make medical decisions based on their independent scientific knowledge, as stipulated in Articles 2 and 3 of Kodeki. According to these

64 Ikatan Dokter Anak Indonesia, *supra* note 25, Art. 24.

65 Undang-Undang Kesehatan, *supra* note 34, Art. 137.

66 Majelis Kehormatan Etik Kedokteran Indonesia, *supra* note 57, penjelasan Art. 1.

67 Suci Maharani and Ashif Az Zafi, "Respon Masyarakat terhadap Pelaku Transgender," (2020) 9:1 *Jurnal Intelektualita: Keislaman, Sosial, dan Sains* 197-199.

articles, a doctor is required to always work professionally, meaning they must provide the best possible service and apply their scientific competence as a doctor. In other words, even if there are societal or religious disagreements regarding GAT, a doctor's rationalization for performing or not performing depends on their independent medical knowledge. The fundamental question that must be answered by a doctor is whether GAT brings more benefits or harm to children experiencing gender dysphoria.

The answer to this question must be accompanied by considering that doctors are obligated to take a holistic and rational approach to healthcare, with functions that are in the form of promotion, prevention, cure, rehabilitation, and palliative care. GAT needs to be evaluated for its effectiveness in treating gender dysphoria and its level of harm. Can the solution to the psychological condition be effectively addressed with medical intervention and low levels of harm? Every doctor faced with such cases is required to assess holistically and rationally what actions are best for children experiencing gender dysphoria as a psychological condition.

IV. EVALUATING THE STATUS QUO

With the absence of positive law regulating GAT in Indonesia, there is a preliminary conclusion that GAT is generally allowed and left to the discretion of individual doctors to perform. There is only one provision related to genitoplasty that can be found in Article 137 of the Health Law; however, this provision does not specifically address the status quo of GAT in the context of this discussion. The absence of regulation in this regard needs to be reevaluated: is it appropriate for the state not to be involved in the application of GAT in Indonesia? If the state needs to be involved, the next question is to what extent the state can be involved. Conversely, if the state cannot be involved, there must be a strong rationale for it.

1. Calculating the Benefits and Impacts of GAT

The first aspect that needs to be assessed is the consideration of the benefits and impacts resulting from GAT. How significant and effective is the implementation of GAT in addressing gender dysphoria issues, and how much harm does it cause? Are there other methods that are more effective or at least equally effective but have lower harm potential or even no harm at all?

a. The Benefits and Impacts of Puberty Blockers

First and foremost, the effectiveness and impact of GAT that must be conveyed are related to Puberty Blockers (PB). Besides their effect on biological development, the use of PB in children experiencing gender dysphoria offers several benefits for the child.

Firstly, hormone medical interventions can reduce anxiety in the child, which also affects their social development.⁶⁸ According to a study conducted by Anna L. Olsavsky and her colleagues, hormonal medical interventions, along with social support from the family, have positive effects on the child's mental health.⁶⁹ Secondly, the use of PB provides time for the child to explore and decide whether or not to proceed with gender-affirming surgery.⁷⁰ Thirdly, it assists children experiencing gender dysphoria in adapting after undergoing gender changes in adulthood.⁷¹ Fourthly, the surgical outcomes appear better in children who have used pubertal suppression early rather than those who start later.⁷² Fifthly, children who do not have easy access to pubertal suppression are more likely to seek alternative, potentially illegal methods.⁷³

In contrast to the opinions above, Sarah C. J. Jorgensen and several other researchers believe that research on the benefits and impacts of GAT on children among experts is still lacking due to the limited updates in research.⁷⁴ They argue that one reason for the lack of updates in research on the impact of GAT is that many experts argue based on an affirmative model, meaning that the use of GAT can prevent children with gender dysphoria from thinking about ending their lives. In reality, data on GnRHa's ability to reduce the risk of suicide comes from low-quality surveys that do not adequately represent the transgender community.⁷⁵ This is also supported by the results of a survey conducted by Polly Carmichael and her colleagues, which found that there were no psychological changes in patients using GnRHa.⁷⁶ These findings contradict the results of previous research conducted in the Netherlands, which found an improvement in psychological conditions from initially poor to good in GnRHa users.⁷⁷

68 Peggy T. Cohen Kettenis, *et.al.*, "Puberty Suppression in a Gender Dysphoric Adolescent: A 22-Year Follow-Up," (2011) 40:4 *Arch Sex Behav* 843-844.

69 Anna L. Olsavsky, Connor Grannis, Josh Bricker, *et.al.* "Associations Among Gender-Affirming Hormonal Interventions, Social Support, and Transgender Adolescents' Mental Health," (2013) 72:6 *Journal of Adolescent Health* 860-868.

70 Kimberly LL, Folkers KM, Friesen P, *et.al.*, "Ethical issues in gender-affirming care for youth," (2018) 142:6 *Pediatrics*.

71 Kettenis, *et.al.*, *supra* note 68, 843-844.

72 *Ibid.*

73 *Ibid.*

74 Sarah C. J. Jorgensen, *et. al.*, "Puberty blockers for gender dysphoric youth: A lack of sound science," (2022) 5:9 *Journal of the American College of Clinical Pharmacy* 1005.

75 Michael Biggs, "Puberty lockers and suicidality in adolescents suffering from gender dysphoria," (2021) 50:4 *Archive Sex Behaviour* 1845.

76 Polly Carmichael, Gary Butler, Una Masic., *et. al.*, "Short-term outcomes of pubertal suppression in a selected cohort of 12 to 15 year old young people with persistent gender dysphoria in the UK," (2021) 16:2 *PLoS ONE* 1-26.

77 Annelou L C de Vries, Thomas D Steensma, Theo A H Doreleijers, and Peggy T Cohen-Kettenis, "Puberty suppression in adolescents with gender identity disorder: a prospective follow-up study," (2011) 8:8 *J Sex Med* 2276-2283.

Biologically, long-term use of GnRHa can reduce bone mineral density.⁷⁸ An internal endocrinologist researcher, Mariksa C. Vlot, has noted that in over 50% of patients using GnRHa, their bone mineral density decreases.⁷⁹ In addition to reduced bone mineral density, GnRHa also affects injection site abscesses, leg pain, headaches, weight gain, and emotional instability.⁸⁰ Common side effects of GnRH agonists and antagonists include symptoms of hypogonadism such as flushing, gynecomastia, fatigue, weight gain, fluid retention, erectile dysfunction, and decreased libido.⁸¹ Long-term therapy can lead to metabolic disorders, weight gain, worsened diabetes, and osteoporosis.⁸² Rare but potentially serious adverse events include transient exacerbation of prostate cancer due to a testosterone surge at the first GnRHa injection and pituitary apoplexy in patients with pituitary adenomas.⁸³

b. The Benefits and Impacts of Cross-sex Hormone Therapy

While using hormone therapy, some physical changes in children are not permanent and can be reversed, such as changes in skin texture, menstrual suppression, and its impact on libido.⁸⁴ However, some physical changes in the child's body will remain permanent after hormone therapy, such as breast development in males using estrogen. On the other hand, the use of testosterone in females will permanently alter physical characteristics, such as deepening of the voice, hair thickening, and affecting fertility or infertility.⁸⁵

For transgender women, Asscheman et al. emphasized a warning about potential side effects, namely hypercoagulability caused by estrogen, which can then lead to venous thromboembolism.⁸⁶ Hembree also found that there are several potential medical risks

78 Mittan D, Lee S, Miller E, *et. al.*, “Standards of care for the health of transsexual, transgender, and gender-nonconforming people,” (2011) 13 *Int.J Transgenderism* 165-232.

79 Markisa C Vlot, Daniel T Klink, Martin den Heijer, *et. al.*, “Effect of pubertal suppression and cross-sex hormone therapy on bone turnover markers and bone mineral apparent density (BMAD) in transgender adolescents,” (2017) 95 *Bone* 11-19.

80 Karine Katchadourian, *et.al.*, “Clinical management of youth with gender dysphoria in Vancouver,” (2014) 164:4 *J Pediatr* 906-911.

81 Elizabeth Pan and Rana R. McKay. GNRH agonists vs antagonists in prostate cancer: How to choose. Available online at <https://www.urologytimes.com/view/gnrh-agonists-vs-antagonists-in-prostate-cancer-how-to-choose>. Accessed on 21 September 2023.

82 *Ibid.*

83 Mariana Barbosa, *et.al.*, “Pituitary apoplexy induced by gonadotropin-releasing hormone agonist administration: a rare complication of prostate cancer treatment,” (2020) *Endocrinol Diabetes Metab Case Rep* 1-6.

84 Rosemary Claire Roden, “Reversible interventions for menstrual management in adolescents and young adults with gender incongruence,” (2023) 17:6 *Ther Adv Reprod Health* 1-14.

85 Marta R. Bizic, Milos J, Slavica P, *et. al.*, “Gender Dysphoria: Bioethical Aspects of Medical Treatment,” (2018) *BioMed Research International* 3-4.

86 Asscheman H, *et. al.*, “Venous thrombo-embolism as a complication of crosssex hormone treatment of male-to-female transsexual subjects: a review,” (2014) 46 *Andrologia* 791-795.

associated with administering testosterone to patients who want to transition to males, such as erythrocytosis, liver dysfunction, coronary heart disease, hypertension, and breast or uterine cancer.⁸⁷ Meanwhile, the medical risks of administering estrogen include thromboembolic disease, macroprolactinoma, breast cancer, coronary heart disease, cholelithiasis, and hypertriglyceridemia. In children who have not undergone natural puberty and use puberty blockers without accompanying hormone therapy, there can be side effects such as flushing, flat mood,⁸⁸ decreased bone density,⁸⁹ and even fertility disturbances.⁹⁰

One of the medical consequences is cancer caused by the addition of estrogen hormones for transgender individuals. According to a specialist in dermatology and venereology, Titi Moertolo, "Estrogen hormones are steroid compounds that function as triggers for the development of reproductive and sexual organs in both women and men. Continuous stimulation of estrogen hormones will result in the proliferation of cancer cells."⁹¹ Cases like this often occur in individuals undergoing genitoplasty. This is because before the surgical procedure is performed, patients are expected to undergo hormone therapy for approximately 12 months to facilitate the transition from their previous gender to their new gender.⁹²

c. The Benefits and Impacts of Genitoplasty

Through the mechanism of genitoplasty, only the appearance of the genitalia is changed, but these artificial genital organs cannot function as the natural genital organs possessed by biological males or females. One crucial aspect that cannot be replaced is the testes' function in producing sperm. Surgeons cannot create functioning testes to produce sperm and other hormones unless these hormones are injected. Similarly, they cannot replicate ovaries and a uterus, which are vital for female reproductive functions.

Another danger that can occur to patients undergoing genitoplasty is the development of a hematoma.⁹³ A hematoma is an abnormal collection of blood outside blood vessels, which can cause swelling in any part of the body.⁹⁴ Furthermore, a major drawback of genitoplasty is that patients are unable to reproduce because many tissues

87 Hembree, *et. al.*, "Guidelines on Gender Dysphoric/Gender-Incongruent Persons," (2017) 102:11 *J Clin Endocrinol Metab* 3886.

88 Cal Horton, "Experiences of Puberty and Puberty Blockers: insights From Trans Children, Trans Adolescents, and Their Parents," (2022) *Journal of Adolescent Research* 18.

89 Mary O. Stevenson, *et.al.*, "Osteoporosis and Bone Health in Transgender Persons," (2019) 48:2 *Endocrinol Metab Clin North Am* 424.

90 Roden, *supra* note 84, 7.

91 Rachel Fisher, *et. al.*, "Decisional Regret About Surgical and Non-Surgical Issues After Genitoplasty Among Caregivers of Female Infants with CAH," (2022) 18:1 *Journal of Pediatric Urology* 31.

92 *Ibid.*

93 Arya Andre Akhavan, *et al.* "A Review of Gender Affirmation Surgery: What We Know and What We Need to Know," (2021) 170:1 *Surgery* 338.

94 *Ibid.*

die during the formation of the new genitalia.⁹⁵ Genitoplasty also carries the risk of common post-operative complications such as tissue damage, blood clots, infection, bleeding, or changes in sensation.⁹⁶ Specific complications can also occur, such as difficulty achieving sexual pleasure and difficulty with toileting.⁹⁷

Surgical failures are also highly possible. Such cases occurred with individuals like Nathan Verhelst, who was born female but underwent genitoplasty, which ultimately failed.⁹⁸ Nathan's body rejected the new genitalia, leading to depression and eventually requesting euthanasia from a doctor. This event serves as tangible evidence of the serious impact of genitoplasty. Additionally, genitoplasty requires a lengthy healing process, and it is not uncommon for individuals to pass away due to the unbearable pain associated with it. Given the multitude of risks involved, the general public often questions whether gender reassignment surgery should be performed.

Psychological hazards are also a negative consequence to consider when undergoing genitoplasty. Individuals who undergo genitoplasty do not always remain satisfied with the changes they experience. There are instances where individuals regret altering their genitalia, known as detransition. According to a survey conducted by the US Transgender Survey of 27,715 transgender adults in the United States, 61.9% of respondents reported undergoing genitoplasty, with 13.1% experiencing detransition.⁹⁹ Out of this group, 15.9% detransitioned due to internal factors. Shortly after undergoing gender reassignment surgery, most people reported feeling better. However, over time, the initial euphoria faded. Sadness returned, but this time worsened by having an irreversible body. 82.5% reported external factors, such as pressure from family and negative societal stigma, as contributors to their detransition.¹⁰⁰ The occurrence of detransition further reinforces societal disapproval of genitoplasty because it can lead to depression and even more severe traumatic experiences than before the surgery.

d. Psychological and Psychiatric Approaches as Alternatives to GAT

Based on the discussion of the benefits and impacts of the three GAT methods above, it is found that GAT poses medical risks to a child's body in both the short and long term. Therefore, it is essential to explore other options that do not pose physical risks to

95 *Ibid.*

96 Steven Rucker, *et al.* "The Rise of the Neophallus: A Systematic Review of Penile Prosthetic Outcomes and Complications in Gender-Affirming Surgery," (2019) 16:5 *Jurnal Sexual Medicine* 665.

97 *Ibid.*

98 BBC Indonesia. Operasi kelamin gagal, transeksual minta disuntik mati. Available online at https://www.bbc.com/indonesia/majalah/2013/10/131003_majalah_lain_belgia_euthanasia. Accessed on 16 February 2023.

99 Adam M Messinger, *et al.*, "Transgender Polyvictimization in the U.S. Transgender survey," (2022) 37:19-20 *J Interpers Violence* 1. See also: Michael Irwig, "Detransition Among Transgender and Gender-Diverse People—An Increasing and Increasingly Complex Phenomenon," (2022) 107:10 *The Journal of Clinical Endocrinology and Metabolism* 1.

100 Messinger, *supra* note 99, 1.

the child's body, such as a psychological approach. The psychological approach recommended for children by E. Lavorato and colleagues is 'Watchful Waiting,' where children experiencing gender dysphoria are given space to explore their evolving gender identity with a neutral perspective on the changes happening to them.¹⁰¹ In this approach, psychologists also play a role in educating parents about gender dysphoria and how to support their child in their decision-making process by considering the costs and benefits they will face.¹⁰² Additionally, psychologists must carefully monitor the child's development to avoid misdiagnosis.

To reduce the likelihood of psychologists making misdiagnoses, the American Psychological Association has developed guidelines for the psychological treatment of transgender and gender-nonconforming people. In essence, these guidelines emphasize the psychologist's role in educating the child about the benefits and impacts of GAT, distinguishing gender identity from sexual orientation, providing psychological support to children still exploring their gender, collaborating with professionals from other disciplines, and continuously studying developments in gender-related knowledge.¹⁰³

Az Hakeem, a psychotherapist, has observed groups of patients who want to undergo gender-affirming surgery and groups of post-surgery patients. From his observations, Az Hakeem found that the group that had not undergone gender-affirming surgery but desired to do so tended to be optimistic, whereas the post-surgery group included patients who regretted their decision and felt resigned. After psychotherapy assessment, a few of Az Hakeem's patients who at first were referred to as having gender identity disorder were later considered to be transvestites and not transgender.¹⁰⁴

From these observations, it becomes clear that medical GAT may not be the solution for every individual experiencing gender dysphoria. Therefore, Az Hakeem emphasizes that not all gender identity disorders are transsexualism/transgender; GAT is not the solution for every gender identity disorder; gender identity-focused psychotherapy tends to be more suitable for individuals with atypical gender identity disorders; psychotherapy practices need to hold collaborative discussion sessions covering topics like binary rigidity, genital centrality, rejection, confusion, and questioning of gender roles; and professionals conducting this psychotherapy must maintain a neutral and open-minded stance.¹⁰⁵

101 Elisabetta Lavorato, *et.al.*, Gender Dysphoria: Overview and Psychological Interventions. In: Bettocchi, C., Busetto, G.M., Carrieri, G., Cormio, L. (eds) *Practical Clinical Andrology* (Cham: Springer, 2023): 269.

102 *Ibid.*

103 American Psychological Association, "Guidelines for psychological practice with transgender and gender nonconforming people," (2015) 70:9 *American Psychologist* 832-864.

104 Az Hakeem, "Psychotherapy for gender identity disorders," (2012) 18 *Advances in psychiatric treatment* 17-24.

105 *Ibid.*

This is essential because gender dysphoria is often difficult to distinguish from conditions closely related to other gender identities, such as Transvestic Disorder, Fetishistic Transvestism, Body Dysmorphic Disorder, autogynephilia, and homosexuality. 'Transvestic Disorder' is a condition where someone enjoys and significantly affects their psychological state when dressing as the opposite sex.¹⁰⁶ 'Fetishistic transvestism' is a condition where someone experiences sexual arousal when dressed as the opposite sex.¹⁰⁷ 'Body Dysmorphic Disorder' is when a child believes their body has physical flaws or deficiencies, leading them to desire to change specific body parts.¹⁰⁸ 'Autogynephilia' is when a male child experiences sexual arousal from fantasies of having a female body.¹⁰⁹ In this context, it can also be very difficult to distinguish between gender dysphoria and homosexuality because a child with a same-sex attraction believes that same-sex attraction is abnormal and feels the need to change their gender.¹¹⁰

Therefore, when dealing with a child experiencing gender dysphoria, it is ideal for all involved parties to be multidisciplinary so that the child's condition can be evaluated from various aspects, including psychological and medical. Before affirming a child's desire to change their gender, psychologists should conduct thorough evaluations to avoid misdiagnosis.

2. Questioning the Legitimacy of a Child's Consent in Administering GAT

All actions to affirm one's gender, whether it's genitoplasty, puberty blockers, or hormone therapy, can be classified as medical procedures. Therefore, patients receiving GAT must provide consent or approval for the medical procedures they will undergo because they are the primary subjects who will directly experience the impact and risks of the medical procedures. Although doctors interpret the medical aspects of their patients' health, they are not allowed to perform medical procedures before the individual has given their informed consent after being fully informed. Doctors or other medical professionals who perform medical procedures must inform patients of the risks, benefits, and alternatives of the medical procedures they will receive.¹¹¹ This subsection questions the legitimacy of a child's consent when it comes to GAT.

106 United Brain Association. Transvestic Disorder. Available online at <https://unitedbrainassociation.org/brain-resources/transvestic-disorder/>. Accessed on 20 September 2023,

107 Mohammad Amir Usmani, *et al.*, "Treatment of Transvestic Fetishism with Fluoxetine: A Case Report," (2012) 6:2 *Iran J Psychiatry Behav Sci* 100.

108 Katharine A. Phillips, "Body dysmorphic disorder: recognizing and treating imagined ugliness," (2004) 3:1 *World Psychiatry* 12.

109 Ray Blanchard, "Early History of the Concept of Autogynephilia," (2005) 34:4 *Archives of Sexual Behavior* 439-446.

110 American Psychological Association. Understanding sexual orientation and homosexuality. Available online at <https://www.apa.org/topics/lgbtq/orientation>. Accessed on September 2023,

111 Parth Shah, *et al.* Informed Consent. Available online at <https://www.ncbi.nlm.nih.gov/books/NBK430827/>. Accessed on 1 August 2023,

In giving their informed consent, a patient must have the capacity to consent to the medical procedures they will undergo. This means that a patient has the ability and proper understanding of the information they are consenting to. Informed consent itself has been recognized in international instruments, such as The Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine, also known as the Oviedo Convention. The Oviedo Convention is the first legally binding document concerning the prohibition of medical procedures on a patient without their consent.¹¹²

In the Oviedo Convention, the right to life or the medical interests of humans is considered more important than social or scientific interests.¹¹³ The Oviedo Convention stipulates that a patient has the right to know information about their health. Concerning GAT for children, the Oviedo Convention prohibits the removal of organs or tissues that cannot be regenerated from individuals who cannot provide informed consent, including children.

The issue of informed consent in this article specifically addresses the validity of a child's informed consent when undergoing medical procedures. A child, as a legal subject involved in a legal relationship in the form of a therapeutic agreement between a doctor and a patient, has the right to know information about their health and the right to give consent regarding the medical procedures they will receive. However, in legal terms, a child is considered not yet capable of exercising these rights, and thus, the child's rights are exercised through the child's representative, namely their parents.

There are several reasons why a child is considered not capable of giving informed consent, particularly because of the word "informed." A child's cognitive ability to understand medical information, ranging from the patient's health condition to the threat of the patient's illness and the impact the patient will experience after receiving medical procedures, is scientific information.¹¹⁴ Therefore, the patient receiving this information must have a certain cognitive level to understand it. If a child were to assume the role of the patient independently, the child would have difficulty analyzing, evaluating, and rationally weighing the available information. This lack of understanding by a child has the potential to lead to incorrect decision-making.¹¹⁵

112 Council of Europe. Free and informed consent as a core principle of the protection of human rights in the field of biomedicine. Available online at <https://rm.coe.int/proceedings-minsk-8-dec-2017-e/16807b4e41>. Accessed on 18 December 2017.

113 Treaty Office. Details of Treaty No.164. Available online at <https://www.coe.int/en/web/conventions/full-list?module=treaty-detail&treatynum=164>. Accessed on 2 September 2023.

114 Lindsey Elizabeth Pearse, "Cognitive Development and The Understanding of Informed Consent," (2008) Thesis, The University of Tennessee at Chattanooga, 4-11.

115 Alireza Parsapoor, *et. al.*, "Autonomy of Children and Adolescents in Consent to Treatment: Ethical, Jurisprudential and Legal Considerations," (2014) 24:3 *Iran J Pediatr* 241.

Medical procedures are often actions that can affect a child's development, so it is highly likely that a medical procedure could change a child's future. A child who is not yet capable of fully understanding medical information from a doctor may not be able to grasp the long-term consequences of a medical procedure. Furthermore, some medical procedures are permanent or irreversible. Careful consideration is needed before a patient agrees to receive GAT. Such considerations are unlikely to be fully understood and made by a child. If a child is given the opportunity to decide on this matter independently, the child is likely to choose a course of action they consider beneficial for their current situation without considering the future.

In addition, a child's level of self-awareness can also be a reason why a child should not provide their consent independently in the context of GAT. This is closely related to the understanding of gender dysphoria. Generally, society understands gender dysphoria when a child plays with toys or wears clothing that is different from their gender.¹¹⁶ However, this understanding is incorrect because gender dysphoria is not a condition that can be understood so simply. Studies indicate that a child who plays roles as if they were of the opposite gender is normal behavior.¹¹⁷ This means that parents or the child themselves should not immediately conclude that the child is experiencing gender dysphoria. As they develop, children who, in their early years, behave differently from their physiological condition can behave in accordance with the gender that matches their natural physiological condition.

3. Justification for the State's Presence in the Issue of GAT to Children

Two important questions need to be systematically addressed in this section. These questions are as follows:

1. Does the state need to intervene in addressing this issue?
2. If intervention is necessary and possible, to what extent can the state intervene?

The necessity of state intervention should be examined first through the lens of the state's goals related to health. Indonesia itself lists its national goals in the second paragraph of the Preamble to the 1945 Constitution, one of which is prosperity.¹¹⁸ Furthermore, in the fourth paragraph, the two most relevant ways to achieve prosperity are advancing the welfare of the people and educating the nation.¹¹⁹ The Health Law,

116 Transgender Trend. Are puberty blockers reversible? The NHS no longer says so. Available online at <https://www.transgendertrend.com/nhs-no-longer-puberty-blockers-reversible/>. Accessed on 9 September 2023.

117 *Ibid.*

118 Indonesia, *supra* note 49, Preamble.

119 *Ibid.*

specifically in the Preamble, makes health a crucial aspect of the agenda to promote the welfare of the people.¹²⁰

The fundamental relationship between health and the general welfare can be seen from the definition of health according to the Health Law itself. Health, which encompasses both physical and non-physical aspects, is linked to productivity. This means that good health is a fundamental requirement for productivity. Productivity, in turn, is closely related to efforts to achieve prosperity by producing something beneficial for both individual lives and society as a whole. The state is present to ensure that its citizens are healthy, both physically and psychologically, so that the envisioned prosperity can be realized, as healthy individuals are crucial subjects in achieving that goal. In technical terms, the state's efforts in health maintenance take the form of promotion, prevention, curative, rehabilitative, and palliative measures.¹²¹

The presence of the state in the context of maintaining the health of its citizens has a normative justification, and the justification is then related to the context of GAT (Gender Affirmation Treatment) for children. The first thing to analyze is the significance of children for Indonesia as a nation. Normatively, Law No. 35 of 2014 concerning Amendments to Law No. 23 of 2002 concerning Child Protection has stated that children are crucial subjects who continue the future of the nation and the state.¹²² Protecting children means ensuring that they can live, grow, and develop optimally in accordance with human dignity and human rights.¹²³

Subsequently, this protection is contextualized into events involving children experiencing gender dysphoria. As explained earlier, gender dysphoria can disrupt productivity due to the emergence of psychological health disorders such as stress, anxiety disorders, and others, possibly leading to suicide. In the Indonesian context, the state must not be indifferent to this issue but rather provide health efforts capable of addressing this issue so that these children can regain psychological health.

In the context of this article, the problem-solving mechanism to be questioned is the use of GAT to address gender dysphoria in children. Based on our findings, GAT, whether it is genitoplasty, puberty blockers, or hormone therapy for children, has harmful effects on the physiological and even psychological conditions of these children. Genitoplasty is related to the loss of reproductive organ functions, while both puberty blockers and hormone therapy directly involve the intentional inhibition of natural physiological processes in the body, resulting in various medical complications. We believe that there is an objective anomaly for healthcare professionals who still affirm gender positions through the administration of GAT. A reflective question that can be

120 Undang-Undang Kesehatan, *supra* note 34, Consideration Part.

121 *Ibid.*, Art. 1(2).

122 Indonesia, *supra* note 55, Consideration Part.

123 *Ibid.*, Explanatory of Art. 12.

raised is whether it is justified to cause various medical complications only to affirm one's gender position rather than being grateful for the physiological condition given by God.

On the other hand, there is the issue of effectiveness. The basic proposition from parties in favor of GAT is that any perceived incongruence between physical conditions and gender feelings must always be affirmed. However, in essence, gender dysphoria is a psychological condition, not a medical condition like diabetes or heart disease, so the solution should be more focused on the psychological aspect. Moreover, GAT does not always immediately resolve gender dysphoria, as there are numerous examples of detransition or individuals who regret having undergone it.

This issue becomes more problematic when various doctors who have performed GAT argue that children have already begun to determine their gender identity, giving them full authority to decide what can be done to their bodies.¹²⁴ This argument is based on the right to determine the treatment that can be performed on one's body. However, the legitimacy of a child's consent in providing GAT still needs to be questioned. Proper guidance from parents and doctors is crucial to explaining the medical impacts. Parents should not always affirm all of a child's desires without rationally considering the effectiveness and harm of GAT. Additionally, doctors have the freedom to interpret and prescribe, rather than children forcing GAT upon themselves.

From these findings, the absence of Indonesia's state presence in being involved in the issue of providing GAT to children raises constitutional questions. Instead of the state being responsible for maintaining the health of children, it allows medical procedures that have physiological damage to these children due to its silent or unregulated stance, which is essentially the same as allowing it. The state's presence in regulation is a concrete form of fulfilling children's health rights, namely avoiding the negative impacts of using GAT, such as the loss of reproductive organs and the emergence of various medical complications.

If the state is to be present in this issue, its presence needs to be careful. This caution relates to the competence and freedom of doctors to make medical treatment choices based on their knowledge so that the state is not seen as authoritarian when intervening without consulting relevant experts.

The initial step that the state needs to take is to encourage and facilitate a college of medical professionals, consisting of relevant medical associations, to discuss guidelines for addressing issues faced by children experiencing gender dysphoria. The state should request the college to issue guidelines on addressing the problems of children with gender dysphoria. Furthermore, the involvement of relevant psychological associations is essential because the issue of gender dysphoria is more appropriately resolved through psychological means. Objectively, GAT should not be included as an option for problem-solving. Afterward, as the subsequent output, the state can make a clear

124 Stephen B. Levine and E Abbruzzese, "Current Concerns About Gender-Affirming Therapy in Adolescents," (2023) 15 *Current Sexual Health Reports* 113-123.

prohibition regarding the use of GAT for children with gender dysphoria and provide established psychological services to help address the issues faced by these children.

V. CLOSING

The issue of addressing gender dysphoria in children through GAT (Gender Affirmation Treatment) raises two opposing perspectives. On one hand, based on the right to bodily autonomy, every child, along with their parents or guardians, is considered to have the right to choose GAT to affirm the gender identity of these children. On the other hand, the significant harm compared to the partial psychological benefits of using GAT in the context of gender dysphoria necessitates the presence of the Indonesian state to support the preservation of the health of its citizens, including children who are the assets of the nation and the state's future.

This article has identified a fact that is difficult to ignore, which is the damaging impact of GAT. It is challenging to accept the approval of various medical professionals for this mechanism unless the basis of their argument is not founded on scientific medical aspects but rather on social and rights-based grounds. This fact has been obtained with the assistance of relevant scientific research in the fields of medicine and psychology. As a result, there is a proposition that needs to be emphasized, namely that it is not justified to cause various medical complications only to affirm one's gender identity, and GAT is not an effective solution. Indonesia has legal justifications to be present in this issue, although this presence should also involve relevant medical associations in establishing guidelines for addressing gender dysphoria in children that are not resolved through GAT. The state's silence and lack of regulation are equivalent to neglecting the fulfillment of children's health rights concerning the impacts of GAT.

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