

CHAPTER 11

THE PROTECTION OF THE HEALTH RIGHTS OF CHILDREN

11.1 Introduction

This Chapter examines how children's health rights can be promoted and protected through legislation and policy. As such it covers aspects such as accessing the health rights of children, the right of children to basic health care services, consent to medical treatment and or surgical intervention, HIV testing, issues relating to confidentiality of medical information, access to contraceptives, and access to termination of pregnancy.

A sample of the sort of problems that may arise in this context is given by Ngwena:¹

Contraceptive and abortion treatment may bring the child and the parent into conflict. A well-meaning parent may vehemently object to a daughter receiving contraceptive or abortion treatment without parental knowledge and approval. A parent may, on the other hand, wish to impose on the daughter contraceptive or abortion treatment regardless of the daughter's views on the matter. With or without the support of the parent the child may be inclined to reject treatment, including life-saving treatment.

11.2 Accessing Children's Health Rights

11.2.1 Introduction

Children's health care rights are currently scattered throughout a number of different pieces of legislation, making it difficult to determine what health rights children are entitled. This is compounded by the lack of a charter of children's rights to health and policy guidelines from the Department of Health on the nature and level of care that children and youth with HIV or AIDS are entitled to within the public health system. As a result, children do not always receive appropriate treatment in hospitals and clinics.

1 Charles Ngwena 'Health care decision-making and the competent minor: The limits of self-determination' (1996) *Acta Juridica* 132 at 133.

The Bill of Rights in Chapter 2 of the 1996 Constitution contains a number of references to health care rights.² Section 27(1) of the Constitution provides every person with rights of access to health care services, whilst section 28(1)(c) of the Constitution provides that amongst others, every child has the right to basic nutrition, shelter, basic health care services and social services.³

The most important health provisions in the Child Care Act are those relating to consent to medical treatment and surgical intervention in certain circumstances.⁴ Although the Act makes reference to the medical treatment of children, it does not provide for the right of children to a certain standard medical care.⁵

The primary purpose of the Health Act 63 of 1977 is to provide for the promotion of health and the co-ordination of health services.⁶ In section 10 of the Act, the state's responsibility to its citizens with regard to health care is stated as being:

2 See, for example, sections 12, 24, 27, 28 and 35.

3 See in this regard, the Constitutional Court decision **Soobramoney v Minister of Health, KwaZulu-Natal** 1998 (1) SA 765 (CC). See further Craig Scott and Philip Alston 'Adjudicating constitutional priorities in a transnational context: A comment on Soobramoney's legacy and Grootboom's promise' (2000) 16 **SAJHR** 206; Ferdinand van Oosten 'Financial resources and the patient's right to health care: Myth and reality' (1999) 32 **De Jure** 1; Frank Michelman 'The Constitution, social rights and reason: A tribute to Etienne Mureinik' (1998) 14 **SAJHR** 499; Geraldine van Bueren 'Alleviating poverty through the Constitutional Court' (1999) 15 **SAJHR** 52.

4 Section 39 of the Act.

5 For a discussion of these provisions, see sections chapter 6 at 6.3.4 and 6.4.7 above. See also 11.4 below.

6 Bryan K (Draft) 'Review of the legislation affecting child health in South Africa' October 1998, compiled for the Community Law Centre, University of the Western Cape and the Child Health Policy Institute, University of Cape Town.

To promote the health of the inhabitants of the Republic so that every person shall be enabled to attain and maintain a state of complete physical, mental and social well-being.

This very broad definition which applies to both children and adults does not create a right of access to health care services or treatment.⁷ Instead it places an obligation on the state to promote the health of individuals.

The existing Health Act, 1977 is in the process of being redrafted and the last draft Bill is dated 28 February 2001. This Bill will be published for comment later in the year. Although the Bill does not have a separate section dealing with the rights of children, it does provide a link to the Child Care Act in its reference to a 'user'. The Bill defines a 'user' as being -

the person receiving treatment or using a health service; and where the person concerned is below the age contemplated in section 39 (4) of the Child Care Act, 1983, or is incapable of taking decisions, in certain circumstances may mean -

- (a) the person's next of kin;
- (b) a person authorised by law or court order to act on that person's behalf; or
- (c) an executor of that person's deceased estate.

11.2.2 **Comparative systems in other countries**

⁷ Research paper on children living with HIV/AIDS.

In 1989, Columbia adopted a Code of Children and Minor's Health Rights.⁸ The Philippines have also codified children's health rights.⁹ The Ukraine has introduced a special provision which allows parents (or persons acting on their behalf) of children under the age of 14 who are infected with HIV, the right to remain in hospital with such children and to receive a temporary disability benefit if they cannot work during this period.¹⁰ A number of countries such as Norway, Italy (Lombardy and Abruzzo) and France have also introduced special measures to protect the rights of children within hospitals. Some of these measures include:¹¹

- measures to avoid or reduce periods of hospitalisation;
- steps to ensure the appropriate design and equipping of children's wards, e.g. ensuring that play rooms exist;
- authorisation for children to be visited outside of ordinary visiting hours; and
- assurance that sufficient information will be provided to parents and children regarding their illness and treatment.

Chapter VII of the new India Children's Code Bill, 2000 is headed 'Provisions regarding health and

8 Columbian Code for Minors, see sections 2 - 17 quoted in Harrison S **A Review of International Maternal and Child Health Legislation** (2nd edition) 1.

9 Ibid.

10 Ibid at 71.

11 Ibid at 71 - 72.

nutrition', although the bulk of the provisions clearly are preventative and early intervention measures. Section 51(1) of the Bill, for instance, places an obligation on the State Government to provide adequate health services and facilities to children, 'both before and after their birth and through the period of growth', to ensure their full physical, mental and social development. The section further provides that the scope of such services must be progressively increased so that within a targeted period all children in the country are provided with and enjoy optimum conditions in health care for their balanced growth.

In order to increase the rate of child survival in India, especially the girl-child, the draft Bill¹² places special emphasis and importance on the following areas, namely: -

- (a) the prevention of child marriages;
- (b) the age of the mother in relation to child birth, the spacing of pregnancies, the services to be provided and care to be received during pregnancy and child birth;
- (c) care of the new born;
- (d) time-bound immunization programme and properly spaced scheme till the child attains five years of age;
- (e) adequate nutrition and health care;
- (f) safe water supply and basic sanitation.

Section 52 of the India Bill states that the State Government must formulate suitable schemes to provide sufficient care to women during pregnancies which may 'include early registration of pregnant women for anti-natal care, universal coverage, tetanus injection supplemented with iron and folic acid, timely identification and treatment of maternal complications, promotion of clean deliveries by trained personnel, which may include imparting of training to the local mid-wives or dais in modern methods of handling deliveries and recognising them as such increasing the institutional delivery rates, management of obstetric emergencies, birth spacing, timing and limitation, improvement of maternal care facilities, and media efforts to promote the awareness of

12 Section 51(2) of the draft Bill.

safe motherhood in the community'. This provision is built on the recognition that maternal death affects the rate of child survival and is detrimental to the health and development of the child.

Also informative is section 55 of the draft Indian Children's Code Bill, 2000. It reads as follows:

Preventative measures against diseases and malnutrition

(1) The State Government shall take adequate measures to combat disease and malnutrition affecting children residing in the State.

(2) The main causes for infant mortality in India have been found to be low birth weight, diarrhoea and acute respiratory infections which causes morbidity in children, absence of complementary feeding during six months to eighteen months wherein the infant is most vulnerable to infection, iodine deficiency, affliction of cretinism, mental retardation and motor handicaps, blindness, seasonal food shortages and the last but not the least, continuing gender disparity in intra-familial distribution of food, and steps shall be taken to minimize the recurrence of the above conditions so as to promote the general health of children.

(3) To combat the general prevalence of malnutrition, both the Central and State Governments shall initiate programmes providing for a package of services, comprising supplementary nutrition, immunization, and health and referral services for the children below two years of age, health check-up, immunization and supplementary nutrition for pregnant and lactating women.

(4) The programmes referred to in sub-section (3) shall take the form of assistance being rendered to the non-governmental or other organizations in the local area and the Government shall have a clear obligation to ensure access to proper nutrition and an efficient and adequate public distribution system.

(5) The measures that may be taken to prevent malnutrition may include -

(a) the child's right to colostrum in the first few days of its birth, exclusive breast feeding for four to six months and an adequate supplementation thereof;

(b) nutrition and well-being shall be achieved through delivery of services, capacity building and empowerment, and ensuring the three necessary conditions of food, health and care;

(c) community groups working on local malnutrition problems should approach the local Pnachayats and State Governments for help in the form of money, endorsements, contacts, transportation, or moral support and encouragement and the State should help such community groups;

(d) to conduct all the above activities, the State Government shall adopt a holistic approach towards preventing malnutrition.

11.2.3 **Comments received**

The research paper on Children Living with HIV/AIDS¹³ poses various questions relating to children's health rights. Comments received on these questions as well as on Issue Paper 13 are incorporated into this Chapter. In the research paper on children living with HIV/AIDS respondents were asked to comment on the following (preliminary) recommendations:

- (a) It is recommended that in the light of the legislation in both Columbia and the Philippines where the health rights of children have been codified, a charter of children's health rights be drafted for broad consultation and discussion. This document could then be used as the basis for preliminary discussion regarding the placement of such rights, ie whether they are more suitably placed in the Child Care Act or the National Health Bill.
- (b) In order to protect the rights of children infected with or affected by HIV/AIDS it is recommended that such a charter includes the following:
- the right to non discrimination on the basis of HIV status;
 - equal access to health care services regardless of HIV status;
 - access to terminations of pregnancy;
 - the provision of HIV/AIDS prevention information/health promotion information;
 - confidential access to contraceptives regardless of age;
 - informed consent obtained before HIV testing and testing only undertaken when it is in the child's best interests;
 - a child's right to confidentiality regarding their HIV status maintained;
 - the right to be treated with dignity regardless of health status;
 - to be provided with treatment of an acceptable standard;
 - protection against female circumcision and other harmful traditional practices;
 - an accessible complaint procedure; and
 - the right to use alternative health care systems if so desired.
- (c) Following the legislation in Norway, Italy and France it is recommended that the Department of Health, in conjunction with other role players, develop and adopt a national policy which

13 See Chapter 1, footnote 8.

- protects the rights of children who have to be hospitalised.
- (d) The Department of Health should develop and adopt clinical guidelines on the appropriate treatment and care which children and youth with HIV/AIDS can expect to receive through the public health system.

Childline Family Centre agreed with the recommendations made, but suggested that greater emphasis should be placed on the child's rights to have his or her mental and psychological health needs attended to. The respondent contended that this is important for children who have suffered the loss of parents and who may be assuming responsibility to care for the terminally ill, or for younger siblings. It is further submitted that the health policy for children should include provision of practical support for children who are nursing terminally ill parents.

The focus group participants agreed with the recommendations made. In respect of the right to be protected against female circumcision and other harmful traditional practices, the group suggested that the right to be protected against unhygienic male circumcision should also be included. The group, however, believed that the life skill component of circumcision schools was very positive and should therefore not be totally scrapped. Thus, the group suggested that female circumcision should be outlawed, whilst provision should be made for greater protection of boys against unhygienic circumcision. The group agreed with the recommendation that the charter should include the right to alternative health care systems if so desired and suggested that this should be a ground for removing a child from hospital.

11.2.4 Evaluation and recommendation

The Commission recommends that the following health rights for children be included in the National Health Bill:

- **the right not to be unfairly discriminated against on the basis of HIV/AIDS status;**
- **equal access to health care services;**
- **right to mental and psychological health care;**
- **the provision of HIV/AIDS prevention information/health promotion information;**
- **confidential access to contraceptives regardless of age;**
- **informed consent as a prerequisite for HIV testing, and testing only when it is in the child's best interests;**

- **a child's right to confidentiality regarding his/her health status;**
- **the right to be treated with dignity regardless of health status;**
- **treatment of an acceptable standard;**
- **protection against female genital mutilation;¹⁴**
- **right of boys not to be subjected to unhygienic circumcision;¹⁵**

14 See also 10.2.11 above.

15 See also 10.2.11 above.

- **protection against other harmful cultural practices;**¹⁶
- **an accessible complaints procedure;**
- **the right to use alternative health care systems if so desired.**

The Commission further adopts recommendations (c) and (d) in 11.2.3 above.

11.3 **Children's right to basic health care services**

11.3.1 **Introduction**

In order to promote and fulfill the right to basic health care services as set out in section 28(1)(c) of the Constitution, the national Department of Health is providing free health care services to children under the age of six years old. At provincial level, the Departments of Health have introduced various measures to promote and fulfill the right of children to basic health care services. For example, the Gauteng Department of Health is serving children in rural areas and informal settlements through mobile and container clinics. Homeless children are referred to places of safety where primary health care services are rendered. Community rehabilitation services are provided to address the needs of children with disabilities and a policy to address the backlog on assistive devices had been implemented. Home-based care is offered to children living with HIV/AIDS.¹⁷

11.3.2 **South African Law and Policy**

Section 27(1)(a) of the Constitution states that all persons have the right to have access to health care services, subject, however, to the state's available resources. In addition to this, section 28(1)(c) of the Constitution states that every child has a right to basic health care services. This

16 See 10.2.11 above, and 21.5 below.

17 South African Human Rights Commission 2nd **Economic and Social Rights Report 1998 - 1999** September 2000.

right is not subject to the availability of state resources.

Children's right to shelter as set out in section 28(1)(c) of the Constitution has recently been tested in **Government of the RSA and Others v Grootboom and Others**.¹⁸ Although the court's focus was on the right to shelter, some conclusions about the scope of the right to basic health care services may be inferred from the reasoning of the court. The court held that section 28(1)(c) did not create a direct and enforceable claim upon the state by children. Rather it was argued that section 28(1)(c) must be understood in the context of the primary duty of parents towards their children.¹⁹ Thus, the right to 'basic nutrition, shelter, basic health care services and social services' must be read with the right of the child to 'family care or parental care, or to appropriate alternative care when removed from the family environment'.²⁰ Consequently, the constitutional duty as regards children's rights in section 28(1)(c) entails a primary obligation which rests upon parents to ensure basic nutrition, shelter and basic health care services for children. Only in default, when children lack parents or families does the state assume a primary obligation for the fulfilment of these rights.²¹ However, as the rights in section 28(1)(c) are not expressly limited by the 'progressive realisation' and 'limited resources' principles, the government has an obligation to immediately make these rights a reality and cannot argue a lack of resources as a defence in a court of law.²²

18 2001 (1) SA 46 (CC).

19 Julia Sloth-Nielsen 'What's left for the rights? The child's right to social services, the right to social security and primary prevention: considering socio-economic rights in the provisioning for South Africa's proposed Children's Statute' Children's Rights Project, Community Law Centre, University of the Western Cape (unpublished).

20 See also par 76 of the **Grootboom** case.

21 Sloth-Nielsen 'What's left for the rights?' Children's Rights Project, Community Law Centre, University of the Western Cape (unpublished).

22 **South African Health Review** 2000 at 6.

The state's responsibility to ensure that the basic health care needs of children with additional health care needs are met, is unclear. It can be argued that the provision of anti-retroviral drugs to HIV positive children is essential to preserve or improve their health and can therefore be considered as a basic health care need. Likewise, the provision of assistive devices and rehabilitation services to children with disabilities are essential to improve their level of functioning within society.

However, according to the **Grootboom** case, the state has a primary responsibility to provide basic health care services only to children who lack a family environment. The health care needs of children of families living in dire poverty health care could thus be marginalised.

Although the White Paper for the Transformation of the Health System does not directly define 'basic health care services', a definition may be deduced from the goals identified in the paper. Regarding maternal and child health services, the White Paper provides that all health facilities, as far as possible, must render these services on a one-stop basis, making services as close as possible to one another. Included in maternal and child health services, are those services which relate to reproductive and sexual health. Implementation strategies include diagnosis, treatment and counselling services for HIV/AIDS and other sexually transmitted diseases at all health centres.²³

The White Paper on the Integrated National Disability Strategy, 1997 notes that legislation fails to protect the rights of people with disabilities and through legislation, barriers are created to prevent people with disabilities from accessing equal opportunities. Poor children who are disabled are particularly excluded as they have poor access to appropriate health care services. The White Paper also proposes free access to assistive devices and rehabilitation services for children under the age of six who have disabilities. The White Paper, bolstered by the Constitution, seems to indicate the state's intention to create legislation which would address the different basic health

23 Bryan K 'A review of legislation affecting child health in South Africa', November 1998, compiled for the Community Law Centre, University of the Western Cape and Child Health Policy Institute, University of Cape Town.

needs of disabled children.²⁴

11.3.3 **Comments received**

24 Ibid.

Commenting on Issue Paper 13,²⁵ the Department of Paediatrics and Child Health at the University of Cape Town submitted that there is a need for a more precise definition of 'basic health care services' to which all children are constitutionally entitled. The Department contended that the scope of the definition of 'basic health care services' should be extended beyond essential primary health care to include a range of health care services for children with special needs. The Department believes that the definition of 'basic health care services' must also include effective highly specialised health care services.

The Child Health Unit of the same Department recommended that legislation that affects child health must include a definition of 'basic health care services' and an explanation of the extent to which children with special needs may be provided with additional services to meet their basic needs.

11.3.4 Evaluation and recommendations

The Commission recommends that -

- **Children's right to basic health care services be confirmed in both the new children's statute and the National Health Bill.**
- **The National Health Bill must set out the core minimum requirements for the state in providing for the health of all children, including the state's responsibility in providing for the basic health care needs of children with additional health care needs.**

11.4 Consent to medical treatment or surgical intervention

11.4.1 Introduction

In respecting the autonomy and dignity of a person, sound information should be provided to a patient which will allow him or her to make informed decisions in full knowledge of the risks of any proposed medical treatment or surgical intervention. As far as it relates to consent to testing for

25 S A Law Commission **Collation of comments on Issue Paper 13: Review of the Child Care Act.**

HIV, the following problems are being experienced:

- Children are frequently subjected to HIV testing without informed consent. There is a view that the results of these tests are often used to discriminate against HIV positive children resulting in them being denied appropriate treatment and given sub-standard care.²⁶ There is also a contrary view that HIV testing is essential for proper permanency planning, care and case management with regard to abandoned babies.
- Urgent or emergency testing is frequently done on children as a way of avoiding obtaining consent and undertaking counselling with the parent or guardian. This is so despite the fact that very few clinical situations arise where a patient's HIV status is required so urgently that ordinary consent procedures need to be bypassed.²⁷
- In a society characterised by high degrees of mobility and in which 20% of children do not live with their biological parents²⁸ contact between health care workers and guardians may be extremely difficult. In the health sector this has relevance beyond the HIV/AIDS setting and in the event of medical emergencies, telephonic consent or consent from the medical superintendent is usually obtained. In non urgent situations, as with HIV testing, consent is either dispensed with or management of the child delayed - usually to the detriment of the child.
- Emergency care is dependent on the medical superintendent's consent which is usually only sought for surgical procedures. All other medical care is undertaken at the discretion of the attending medical practitioner. The result is often a conflict between the interests of the health services and those of the child.

11.4.2 South African Law and Policy

26 Information supplied by Mark Heywood at the AIDS Law Project on 12 January 1999.

27 Information supplied by Dr McKerrow on 1 December 1998.

28 McKerrow NH and Verbeek AE **Models of Care for Children in Distress** Pietermaritzburg, 1995; and Simkins C 'Household Composition and Structure in South Africa' in Burman S and Reynolds P (eds) **Growing Up in a Divided Society: The Context of Childhood in South Africa** Johannesburg Raven Press, 1986.

The Constitution provides that everyone has the right to bodily integrity which includes the right to security in and control over their body.²⁹ The Mental Health Act 18 of 1973 stipulates that where a person of any age is unable, because of mental illness, to consent to medical treatment or to an operation, a parent or other authorised person must do so instead.³⁰ The Child Care Act 74 of 1983 sets out the age at which a child is competent to consent to medical treatment. In terms of this Act, a child over the age of 14 years is competent to consent, without the assistance of his or her parent or guardian, to any form of medical treatment.³¹ This means that children over the age of 14, but younger than 18 years cannot consent to an operation without the assistance of their parent or guardian.

In a situation where a child needs treatment or needs to undergo an operation and his or her parent or guardian refuses to give consent, or cannot be found, or is mentally ill, or is deceased then the medical practitioner must approach the Minister for Social Development for the necessary consent.³² In instances where medical treatment is necessary and so urgent that it ought not to be referred to the person legally competent to consent to such medical treatment or operation, the superintendent or medical practitioner acting on his behalf may give the necessary consent.³³

Also, if the head of an institution³⁴ or a person³⁵ in whose custody a child is, has reasonable grounds for believing that the performance of any operation upon or the provision of medical treatment to the child is necessary to preserve his or her life or to save him or her from serious and lasting physical injury or disability and that the need for the operation and medical treatment is so urgent that it ought not to be deferred for the purpose of consulting the parents or guardian of the child, or the Minister, the head or the person concerned may authorise its performance upon or

29 Section 12(2) of the Constitution.

30 Section 60A of the Act.

31 Section 39(4)(b) of the Act. Medical treatment also includes an HIV test.

32 Section 39(1) of the Child Care Act.

33 Section 39(2) of the Child Care Act.

34 An institution in which a child has been placed in terms of the Child Care Act, 1983 or under section 290 of the Criminal Procedure Act, 1977.

35 A person in whose custody a child has been placed in terms of the Child Care Act, 1983 or under section 290 of the Criminal Procedure Act, 1977.

provision to the child.³⁶

However, medical practitioners note the following problems and uncertainties with the consent procedures in the Child Care Act:

- the procedure set out in section 39(1) which requires a medical practitioner to apply to the Minister of Social Development for consent is impractical and widely disregarded in practice;
- consent is not defined in the Act;
- despite the provisions in the Act unauthorised testing continues, particularly on abandoned babies;
- the Act's distinction between 'medical treatment' and an 'operation' is not clear and neither concept is defined within the Act; and
- most practitioners, particularly those working in hospitals report problems with obtaining consent for non-emergency procedures from parents or guardians as they may live a long distance from the hospital, or cannot be contacted by telephone.

36 Section 53(4) of the Child Care Act, 1983.

The National Health Bill provides that subject to any other law, no person or health establishment may provide a user³⁷ with treatment of any nature unless the user has been adequately informed and has consented to the treatment; a law or court order has authorised the treatment; the treatment is necessary for the protection of public health; or any delay in treating the user might result in their death or irreversible damage to their health and the user has not expressly refused the treatment.³⁸

In light of the above, it follows that to perform an operation on a child or to submit him or her to any medical treatment without consent will amount to an invasion of his or her bodily integrity. The position in the Child Care Act does not detract from the rule that the High Court as the upper guardian of all minors may be approached at any time to give consent to medical treatment on behalf of a minor.³⁹

With regard to decisions affecting one's health, the National Health Bill provides that 'every user has a right to participate in any decision affecting his or her personal health and treatment, unless it is not reasonable practicable for the user to participate'.⁴⁰ However, the definition of a 'user' does not give to a child of 14 years and younger the right to participate in a decision regarding his or her medical treatment nor does it give a child over the age of 14 the right to participate in a decision regarding surgical intervention on him or her.

11.4.3 **Comparative review of systems in other countries**

37 See 11.2.1 above for the definition of 'user'.

38 Clause 9 of the Bill.

39 Strauss **Doctor, Patient and the Law** (3rd edition) 6.

40 Clause 7 of the Bill.

In America, the doctrine of informed consent requires that people about to undergo medical treatment be provided with all material information needed to make an informed decision. The determining factor as to what risks are material is that of the 'prudent patient', rather than the doctor's assessment of what should be disclosed.⁴¹ The doctrine of informed consent is also well established in Canada.⁴²

In Zimbabwean law, all persons under the age of 18 years are minors.⁴³ Consent to medical treatment on a minor must in the first instance be provided by their parent or guardian.⁴⁴ If their consent cannot be obtained or is refused, the Children's Protection and Adoption Act provides in section 76 as follows:

- (1) Where the consent of a parent or guardian is necessary for the performance of any dental, medical, surgical or other treatment upon a minor and the consent of the parent or guardian is refused or cannot be obtained within a period which is reasonable in the circumstances, application may be made to a magistrate of the province where the minor is or is resident for authority to perform the treatment.
- (2) A magistrate to whom an application in terms of subsection (1) is made may -
 - (a) after due inquiry and after affording the parent or guardian concerned a reasonable opportunity of stating his reasons for refusing to give the necessary consent or without affording such person opportunity if his whereabouts are unknown or if in the circumstances it is not reasonably practicable to afford him such opportunity; and
 - (b) if satisfied that any dental, medical, surgical or other treatment is necessary or desirable in the interest of the health of the minor;

by order in writing authorise the performance at a hospital or other suitable place upon the minor concerned of such dental, medical, surgical or other medical treatment as may be

41 **Canterbury v Spence** (1972) 464 F (2nd) 772.

42 **Reibl v Hughes** (1980) 114 DLR (3RD) 1.

43 Feltoe G and Nyapadi T J **Law and Medicine in Zimbabwe** 42.

44 Ibid.

specified in the order.

In the United States, Florida, an exception is made to the ordinary consent provisions for minors. This allows a medical practitioner to treat a minor's sexually transmitted disease without parental consent. Furthermore they may not inform the parent of this treatment either directly or indirectly (by for example sending a detailed bill for the treatment).⁴⁵ In California, the Family Code⁴⁶ contains a general rule that a parent or guardian must consent to 'medical care' on behalf of a minor. It then sets out a number of exceptions to this rule.⁴⁷ Examples include:

- a caregiver, who is not the parent or guardian may in certain circumstances consent on behalf of the minor;⁴⁸
- a parent, guardian or 'caregiver who is a relative' may assign their consent to medical care powers to another person who is caring for the child, provided they do so in writing;⁴⁹
- a minor, from the age of 12 may consent on their own to mental health treatment, provided certain conditions are met;⁵⁰
- a minor of any age may consent to medical care related to pregnancy prevention;⁵¹ and
- a minor of 12 years or older who has come into contact with a 'communicable disease' or is suffering from a 'sexually transmitted disease' may consent to treatment on their own.⁵²

11.4.4 **Comments received**

The research paper asked respondents to comment on the following recommendations:

45 Harrison S **A Review of International Maternal and Child Health Legislation** (2nd edition) 38.

46 Family Code, Division II, Part 4, chapters 1 - 3.

47 Section 6920.

48 Section 6550.

49 Section 6910.

50 Section 6924.

51 Section 6925(a).

52 Section 6926(a) and (b).

- (a) It is proposed that the legislation confirms the current position in the Child Care Act that children over the age of 14 may consent to medical treatment on their own, whilst until they are 18 they will require parental assistance before they consent to an operation.
- (b) It is proposed that following the Californian approach, the legislation should include a number of exceptions to this general rule. These should include but not be limited to:
- a child of any age should be entitled to obtain information on and access to contraceptives; and
 - a child over the age of 12 should be able to obtain treatment for sexually transmitted diseases.
- (c) Furthermore, following the Californian Family Code, a parent or guardian should be entitled to transfer their parental powers regarding consent (to medical treatment and operations) to a third party, provided the person to whom such power is transferred is the child's caregiver and they have done this in the form of a statement before a Commissioner of Oaths. It is further recommended that the Project Committee debate further the possibility of creating a simple procedure for appointing a guardian for abandoned children, orphans and those living on the streets so that should they need medical care this can be provided.
- (d) It is recommended that the following be considered in the redrafting of the consent provision:
- a simplification of the procedures for obtaining consent;
 - a process for ensuring that consent to treat a minor in non-emergency situations can easily be obtained from an appropriate and responsible caregiver, who is not necessarily the parent or guardian; and
 - creating a statutory definition of informed consent, medical treatment and operations;
- (e) It is also recommended that the Project Committee debate the appropriate placement of such provisions (ie should they be within the Child Care Act or health legislation?)
- (f) It is recommended that section 60 of the Child Care Act be amended to empower the Minister of Welfare to develop and publish codes of good practice on any matter relating to the welfare of children. In terms of this amendment we would propose that a code of good practice on HIV testing be developed and published, based on the SALC's draft National HIV Testing and Informed Consent Policy⁵³ and the following principles:
- all HIV testing should be undertaken only with the informed consent of the parent, guardian or child themselves, and if it is in the best interests of the child.

This shall mean that no child may be tested for HIV if :

- (i) such information is to be used to discriminate against them; and

- (ii) the information is required due to the irrational fears of staff or other persons dealing with the child (instead universal precautions should be used in every appropriate situation.);
 - pre and post test counselling accompany every HIV test; and
 - confidentiality of the results is maintained and disclosures only made with the consent of the parent, guardian or child themselves.
- (g) Finally, it is recommended that the Department of Health be urged to implement the SALC recommended draft National Testing and Informed Consent Policy.

The focus group participants, in respect of recommendation (a), proposed that children from the age of 10 to 14 should be consulted in matters relating to their health and that children under the age of 10 should be consulted as appropriate to their capacity. In respect of recommendation (e), concern was expressed that the Department of Health has not yet implemented the recommendation that all HIV testing be carried out with pre-test counselling. It was suggested that Departments of Health and Welfare should have an integrated testing policy for children and that this policy should be implemented at provincial level. Further, that all pre-test counselling should be culturally appropriate. In respect of recommendation (f), the group was divided. Some members of the group submitted that the best interest of children not infected by HIV/AIDS should also be considered. Thus, HIV testing should be allowed if it is in the best interest of another child. Whilst other members of the group felt that no mandatory testing should be allowed to avoid stigmatizing HIV infected children.

Comments received on Issue Paper 13 suggested that the terms 'medical treatment', 'informed consent' and 'operation' should be defined and a simple procedure for obtaining consent to provide treatment to children in a non-emergency situation should be provided for. Further, that a simplified procedure should be created for obtaining consent for an operation as the present procedure in section 39(1) is cumbersome and not used. Boys Town submitted that section 39 of the Child Care Act does not make provision for the principal or director of a children's home to give consent to operations. The respondent stated that this is desirable as often the persons entrusted with this task are hesitant to take responsibility for such consent.

11.4.5 **Evaluation and recommendation**

It seems that children are being subjected to non-emergency procedures despite the fact that the

current law implies that children cannot be submitted to any medical treatment or surgical intervention without consent. It is also apparent that the treatment of children in non-emergency situations is often delayed - usually to the detriment of the child. This is so mainly because the person legally responsible for giving consent is not available or difficult to trace. The procedure in terms of which the Minister of Social Development can give consent to medical treatment or an operation in non emergency situations is also criticised for being impractical. **For these reasons the Commission recommends as follows:**

- **That the age at which children may consent to medical treatment be lowered to 12 years, whilst until they are 18 they cannot consent to an operation without the assistance of their parent(s) or guardian(s).**
- **Following the Californian approach, the new children's statute should include the following exceptions to this general rule:**
 - **a child of any age should be entitled to obtain information on and access to contraceptives; and**
 - **any child should be able to obtain treatment for sexually transmitted diseases regardless of age.**
- **A caregiver who is not a parent or guardian of a child may consent to medical treatment for or an operation on that child if that child has been abandoned or his or her parents are deceased.**
- **A parent or guardian of a child may give written consent to a person caring for a child to give consent to medical treatment for or an operation on that child.**
- **The National Health Bill should be amended to provide that children from the age of 12 should be consulted in matters relating to their health and children under the age of 12 should be consulted as appropriate to their capacity.**
- **Following the Zimbabwean approach, section 39 (1) of the a Child Care Act which requires a medical practitioner to approach the Minister for consent for medical treatment to or an operation upon a child in instances where a parent or guardian refuses consent, or cannot be found, or is by reason of mental illness unable to give consent, or is deceased should be amended to provide that the children's court, instead of the Minister, can be approached to obtain the necessary consent for medical treatment or an operation.⁵⁴**

54 See further 23.10.4 below.

- **The new children's statute should explicitly provide that no child may be submitted to any medical treatment or surgical intervention without the child's informed consent, or that of his or her parent or guardian.⁵⁵**
- **Medical treatment or surgical intervention should not unnecessary be delayed in instances where consent in terms of section 39 (1) is needed.**
- **Confusion exists between 'medical treatment' and an 'operation'. These terms are defined neither by the Child Care Act nor by the Heath Act. The latter Acts also do not define 'informed consent'. The Commission therefore invites comments on how the said terms should be defined.**

11.5 **HIV testing in relation to placement of children in need of care**

11.5.1 **Introduction**

55 Informed consent shall include consent, on behalf of a child, by the superintendent of a residential care facility or department or organisation arranging placement of the child in terms of the Child Care Act.

Children in need of care and protection are often tested for HIV before being placed in adoptive and foster care, or residential care facilities. In many cases this testing is carried out without the necessary informed consent, and may also be used to discriminate against children.⁵⁶ There are a number of arguments proposed both for and against HIV testing before placement, many of which were detailed by the South African Law Commission's Project Committee on HIV and AIDS.⁵⁷

Arguments against HIV testing include the following:

- HIV testing is frequently carried out without the requisite consent, since the parent or guardian of the child is not available to consent to the HIV test.
- Furthermore, disclosure of a child's HIV status without the necessary consent is also a breach of the child's right to confidentiality.
- The results of an HIV test may be used to discriminate against a child, in that the child may not be adopted, fostered, or accepted into a residential care facility on the basis of his or her HIV status.
- The positive HIV status of a baby can only be established with certainty by means of an HIV antibody test, at an average of 15-18 months.⁵⁸
- It has been argued that all children available for adoption, fostering and admission to residential care should be regarded as potentially HIV infected.

56 Cameron, E 'Children with HIV or AIDS: Guidelines to pull out and keep' March, 1993 **AIDS Bulletin**.

57 S A Law Commission **Aspects of the Law Relating to AIDS : Working Paper 58** published for General Information and Comment, September 1995.

58 The HIV status of a baby can be confirmed through the Polymerase Chain Reaction (PCR) test at 3 months. This is, however, costly and the health authorities do not routinely offer it.

Arguments in favour of HIV testing include the following:

- It may be argued that HIV testing is in the best interests of the child, in that knowing the HIV status of a child allows the caregiver to plan for and manage the child's health care and welfare appropriately.
- Adoption is a permanent and final placement, and according to welfare organisations it is the policy to inform prospective parents as fully as possible about the child to enable them to make a final decision concerning adoption.
- It is argued that a child who is HIV positive or has AIDS may require expensive health care, and caregivers should be given the opportunity to determine whether they are in a position to care for the child.
- An adoption order may be rescinded on the basis of fraud, misrepresentation and *iustus error*.⁵⁹ If a child is later discovered to be HIV positive, this may be a ground for rescinding the adoption.
- Prospective caretakers have the right to decide whether they feel able to care for a baby with a life-threatening condition.
- Adoption agencies have traditionally arranged for screening for all major health problems, and AIDS should not be treated differently.
- Failure to test for HIV would discourage people from adopting, reducing the pool of prospective adoptive parents.
- Organisations are engaged in recruitment of families who are willing and able to care specifically for children who are HIV positive or have AIDS.
- Testing for HIV assists in ensuring that children are placed as quickly as possible in the most appropriate available form of care.

11.5.2 South African Law and Policy

59 Section 21(1)(b) of the Child Care Act 74 of 1983.

Currently, there is no legislation addressing the issue of HIV testing before the placement of a child in need of care. The Commission's First Interim Report on Aspects of the Law Relating to Aids, 1997 considered the issues of a national policy on HIV testing and informed consent.⁶⁰ The Report recommended that the Minister of Health should adopt a national policy on testing for HIV. The Report further proposed a policy on HIV testing. The proposed policy stipulated the circumstances under which HIV testing can be done with or without informed consent. In terms of the proposed policy, informed consent includes pre-test counselling. The proposed policy further provided that information regarding the results of an HIV test must remain fully confidential, and may be disclosed in the absence of an overriding legal or ethical duty only with the individual's fully informed consent. A National Policy on testing for HIV was consequently adopted by the Department of Health.⁶¹ This Policy does not differ substantially from the policy proposed by the Commission. The National Policy on HIV testing states explicitly that testing for HIV infection at all health care facilities must be carried out with informed consent,⁶² which includes pre and *post-test* counselling. In terms of the

60 See also the Law Commission's **Third Interim Report on Aspects of the Law Relating to Aids** in which a national policy on HIV/AIDS in schools was considered. The Report in particular states that compulsory testing of learners as a prerequisite for admission to any school, or any unfair discriminatory treatment (for instance the refusal of continued school attendance on the basis of the HIV status of the learner), is not justified. However, it is recognised that special measures in respect of learners with HIV may be necessary. These must be fair and justifiable in the lights of medical facts, school conditions and the best interest of learners with and without HIV.

61 Latest draft received from the National Department of Health on 2 July 2001 (not yet published).

62 However, HIV testing may be conducted without informed consent in the following circumstances:

Policy, informed consent means ‘that the individual has been provided with information, they have understood it and based on this they agree to undergo the HIV test. It implies that the individual understands what the test is, why it is necessary and the benefits, risks, alternatives and possible social implications of the outcome’. The Policy further states that informed consent implies the giving of express agreement to HIV testing in a situation devoid of coercion. Referring to the Child Care Act, 1983, the Policy stipulates that a parent or guardian of a child 14 years and younger may give consent to HIV testing of the child.⁶³

11.5.3 **Comparative review of systems in other countries**

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- On an existing blood or tissue sample as part of unlinked and anonymous testing for epidemiological purposes, provided that such testing is carried out in accordance with national legal and ethical guidelines regarding such testing.
 - Where an existing blood sample of a source patient is available, and an emergency situation necessitates testing the source patient’s blood (e.g. when a health care worker has been accidentally exposed to the source patient’s blood in the course of medical procedures), HIV testing may be undertaken without informed consent, but only after the source patient has declined to give his/her informed consent or is unable to do so, and he/she has been informed that the result may be disclosed to the health care worker concerned, but will otherwise remain confidential.
 - Where statutory provision or other legal authorisation exists for testing without informed consent.

63 HIV testing is not regarded as medical treatment or an operation for purposes of the new child care statute.

11.5.3.1 **United Kingdom**

In England, the routine HIV testing of children intended for adoption is sometimes proposed, but is presently discouraged by the British Agencies for Adoption and Fostering (except in cases where there is a clear risk of infection), potential adoptive parents being rather informed that it is not possible to guarantee that a child is not infected.⁶⁴

11.5.3.2 **United States of America**

In the United States, the Centres for Disease Control has recommended in guidelines that adoption organisations should make HIV testing a compulsory part of the health evaluation of children intended for foster-care and adoption. However, the guidelines have in general not yet been accepted by welfare organisations - most organisations prefer a selective case-by-case approach to HIV testing.

11.5.4 **Comments received**

The research paper asked whether respondents agreed with the following recommendations:

- a) A code of good practice should be developed with regard to HIV testing to prohibit mandatory HIV testing, to ensure that all testing only takes place voluntarily and with informed consent, and ensure that HIV testing may only take place where this is in the best interests of the child.
- b) The testing provisions should also take note of the South African Law Commission's *First Interim Report on Aspects of the Law Relating to AIDS*.
- c) The issue of whether requesting prospective adoptive and foster children to undergo HIV testing is in the best interest of the child should be canvassed and debated, and a uniform national policy decision be taken accordingly. The policy decision should be accompanied by clear operational guidelines to ensure that children are placed as quickly as possible, and

⁶⁴ Viinikka S 'Children, Young People and HIV Infection' in Haigh, R and Harris, D (eds) **AIDS : A Guide to the Law** London: Routledge, 1996 at 10.

that placement options are available.

Childline Family Centre stated that the levels of sexual activity between children in care and the level of sexual exploitation of children by other children in institutional care are extremely high. Further, HIV positive children should be aware of their HIV status in order to facilitate the development of responsible management of their own sexual behaviour and to make appropriate decisions. The respondent suggested the implementation of universal management procedures with regard to all children in care to minimise the risk to other children as well as universal educational programmes with regard to sexual activity.

The Cape Law Society submitted that legislation should provide for the mandatory testing of a child in residential care where the possibility exists that he or she may be infected. This would ensure that the child receives the appropriate care and treatment. It is submitted that possible objections based on religious belief may be raised. Lastly, it is essential that a policy be adopted protecting such results as confidential.

The focus group participants said that it is in the best interest of a child to undergo an HIV test before adoption as this will avoid the risk of the child being returned if discovered at a later stage that he or she is HIV positive. The group, however, cautioned against requesting foster parents to undergo an HIV test as this may reduce the number of potential foster parents. It is also suggested that the 'code of good practice' and 'best interests of the child' should be defined.

Question 8 of Issue Paper 13 asked: How should HIV testing, including testing of children in residential care, be approached in legislation? The majority of respondents felt that HIV testing should be allowed if it is in the best interest of the child. For instance, the Natal Society of Advocates contended that HIV should not be distinguished from any other testing for life threatening disease. Thus, a person in whose de facto care a child is should be able to consent to the testing of the child if there is a reasonable belief that the child may suffer from a life threatening disease. The SA National Council for Child and Family Welfare argued that it is important that children in need of alternative care, including residential care, be tested as confidential knowledge has to be provided

to the caregivers. The respondent submitted that this will assist the caregiver to plan appropriate care for a child whose parents have died as a result of HIV/AIDS. Also, the need for the child to know his or her HIV status cannot be overlooked. Some respondents are, however, against the HIV testing of children. For instance, the Health/Human Rights argued that legislation should provide that no child entering residential care should be discriminated against. A list of prohibited grounds of discrimination, which includes HIV/AIDS, should thus be developed. This will protect children from being tested for HIV and from being refused access to a children's home because of their HIV status. The respondent proposed that the code of good practice could set out the following in more detail: (a) when is it in the best interest of the child to be tested, (b) how to obtain informed consent from the child or the parent/guardian, (c) ensuring that confidentiality of the results is guaranteed, (d) the provision of pre- and post-test counselling, and (e) ensuring that the test is undertaken for diagnostic or therapeutic reasons.

11.5.5 Evaluation and recommendation

Although the majority of respondents are in favour of mandatory HIV testing in certain circumstances, the Commission needs to take cognisance of the fact that HIV testing may often not be in the best interest of the child as it can be used to discriminate against the child. **The Commission thus recommends that no child may be tested for HIV without the informed consent of the child or his or her caregiver⁶⁵ and HIV testing may only take place where this is in the best interests of the child.** The best interest of the child shall include testing for HIV where there is reasonable belief that the child may be infected and testing is done to ensure that the child receives appropriate care and treatment. The testing should also take note of the National Policy on testing for HIV.⁶⁶ **The Commission further recommends that pre⁶⁷ and post-test⁶⁸ counselling**

65 Informed consent shall include consent, on behalf of a child by the head of a residential care facility or department or organisation arranging placement of the child.

66 See 11.5.2 above.

67 The National Policy on testing for HIV stipulates that pre-test counselling should include discussions on:

- What an HIV test is and the purpose of the test.
- The meaning of both a positive and negative result, including the practical implications such as medical treatment and care, sexual relations, psycho-social implications etc.

for the child, where applicable,⁶⁹ should take place as the results of an HIV test will undoubtedly have profound implications for the entire family.⁷⁰

The Commission further recommends as follows:

- **The age at which a child may consent to an HIV test should be lower to children 12 years of age and older.**
- **A child under 12 years of age who is of sufficient maturity to understand the benefits, risks and possible social implications of an HIV test may consent to such a test.** However, parental consent to undergo medical treatment for HIV/AIDS will be needed as treatment could have serious financial implications for the parents of such child.
- **Where a child under 12 years of age is not of sufficient maturity to understand the benefits, risks and possible social implications of an HIV test, the person exercising parental authority over that child may consent to the HIV testing of that child.**
- **Where parental consent to an HIV test is unreasonably withheld, the court should be approached for the necessary consent.**

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- Assessment of personal risk of HIV infection.
 - Safer sex and strategies to reduce risk.
 - Coping with a positive test result, including whom to tell and identifying needs and support services
 - An opportunity for decision making about taking the HIV test.
- 68 The National Policy on testing for HIV stipulates that post-test counselling involves one or more sessions and should include discussions on:
- Feedback and understanding of the results.
 - If the result is negative:
 - strategies for risk reduction;
 - possibility of infection in the 'window period'.
 - If the result is positive:
 - immediate emotional reaction and concerns;
 - personal, family and social implications;
 - Difficulties a patient may foresee and possible coping strategies;
 - Who the client want to share the results with, including responsibilities to sexual partners;
 - immediate needs and social support identification;
 - follow up supportive counselling; and
 - follow up medical care.
- 69 Pre- and post-test counselling will not be necessary if the child concerned is not of sufficient maturity to understand the implications of an HIV test.
- 70 Counselling may include counselling for the family. Care should, however, be taken that the child's right to confidentiality is not infringed when counselling is provided to a family member other than the child.

- **Where a child under 12 years of age who is not of sufficient maturity to understand the benefits, risks and possible social implications of an HIV test, is in residential care or awaiting statutory placement, the head of the residential care facility or organisation arranging placement may consent to the HIV testing of that child.**
- **The head of a hospital may only give consent to the HIV testing of a child under 12 years of age who is not of sufficient maturity to understand the benefits, risks and social implications of an HIV test if no parent or person exercising parental authority over the child is available or where no organisation is arranging placement for the child or where the child is not in the care of a residential care facility.**

The Commission takes cognisance of the fact that many parents will not accept a child for adoption until his or her HIV negative status is confirmed. The cost and emotional damage resulting from keeping a healthy child in residential care or a hospital until he or she tests negative at eighteen months is vastly higher than using the Polymerase Chain Reaction (PCR) test.⁷¹ **The Commission therefore recommends that consideration be given to making the PCR test available at state expense for babies requiring placement in terms of this Act for purposes of permanency planning and appropriate selection of placement.**

11.6 **Confidentiality of information relating to the HIV/AIDS status of children**

11.6.1 **Introduction**

The right to confidentiality is frequently breached in the health care and institutional setting. A child's right to confidentiality is of particular importance with regard to his or her HIV status due to the high levels of stigma and discrimination against children infected with HIV/AIDS.

11.6.2 **South African Law and Policy**

71 The PCR test can detect the HIV virus in the blood immediately.

The S A Interim Medical and Dental Council describes the ethical rule regarding confidentiality as follows: 'No practitioner may divulge information regarding the ailments of a patient except with the express consent of the patient or, in the case of a minor, with the express consent of his guardian or, in the case of a deceased patient, with the consent of his next of kin or the executor of his estate'.⁷² A patient's right to confidentiality may be limited in certain circumstances and each situation would have to be considered with regard to its individual circumstances.⁷³ The Medical Association of South Africa (MASA) has identified the following criteria for limiting a patient's right to confidentiality: a grave risk, to a clearly defined third party.⁷⁴ Our courts also recognise the right to confidentiality or privacy as a common law personality right. However, the common law right to confidentiality for children is not confirmed in legislation. Therefore, confusion exists in practice with regard to how this rule should be applied. This has led to an ad hoc approach to confidentiality based on individual interpretations of the 'right to know' and 'best interest of the child' principles.

The National Policy on testing for HIV stipulates that information regarding the result of an HIV test must remain fully confidential and may only be disclosed, in the absence of an overriding legal and ethical duty, with the individual's fully informed consent. The Policy further provides that pre-test counselling should be a confidential dialogue with a suitably qualified person.

The National Health Bill provides that 'every user is entitled to confidentiality of all information concerning the user, including information relating to his or her health status, treatment, or stay in a public or private health establishment'. However, this Bill does not require a person who can lawfully give consent, in terms of section 39(4) of the Child Care Act, to treatment of or surgical intervention on a child to consult with that child before information regarding his or her health status is disclosed.

11.6.3 Comparative review of systems in other countries

72 Rule 16 of the South African Interim Medical and Dental Council's Rules of Practice.

73 In **Jansen van Vuuren and Another NNO v Kruger** 1993 (4) SA 842 (A) the court held that the conflicting interests would have to be balanced: 'However the right of a patient and the duty of a doctor are not absolute but relative. One is, as always weighing up the conflicting interests ... a doctor may be justified in disclosing his knowledge where his obligation to society would be of greater weight than his obligation to the individual'.

74 MASA HIV/AIDS Ethical Guidelines.

In England, children with HIV are guaranteed rights to confidentiality.⁷⁵ The 'need to know' principle is used as a standard when deciding whether or not to make a disclosure.⁷⁶ In **W v Egdell**⁷⁷ the following principles regarding the disclosure of confidential medical information were established:

- (a) disclosures should be limited to those regarded as vitally in need of the information,
- (b) the risk, if the information is not disclosed must be real; and
- (c) this real threat of harm must be physical.⁷⁸

75 **AIDS : A Guide to the Law** at 8.

76 *Ibid* at 10.

77 [1990] Ch 359 (CA).

78 Davies M **Medical Law** 1996 Blackstone Press Ltd 34 - 36.

Italian law provides specific protection against disclosure of the result of an HIV test. Section 4 of Law No. 135/90 states that the result of an HIV test may only be disclosed to the person concerned.⁷⁹

11.6.4 **Comments received**

The research paper asked respondents to comment on the following recommendations:

- (a) It is recommended that the departments of Health and Welfare develop operational guidelines on confidentiality for their respective sectors based on the following criteria:
- disclosure of HIV related information in a medical context should always be made with regard to the best interests of the child principle;
 - attempts should be made to obtain consent from the child's parent or guardian before a disclosure is made;
 - confidentiality should not be breached unless a real risk exists to a third party; and
 - in the light of the levels of discrimination and stigma that exist, medical practitioners should consider the possible consequences of a disclosure before providing this information to third parties.
- (b) A child's right to confidentiality in a medical context be confirmed in legislation by being placed within a charter of health rights.

The S A National Council for Child Welfare, with regard to recommendation (a), submitted that the principles of *best interest of the child* and *a real risk exists to a third party* need to be clearly defined. Childline Family Centre, KZN, suggested that the recommendations should be extended to include consultation with and consent of the child before disclosure of his or her HIV status is made.

The respondent acknowledged, however, that such a consultation process will depend on the age of the child. The focus group participants agreed with the recommendations made. However, the group recommended the following changes: (i) In respect of recommendation (a), that not just medical practitioners but all other child care professionals should consider the possible consequences of disclosing a child's HIV status before providing information to third parties; (ii) in respect of recommendation (b), that the words 'in a medical context' be deleted.

79 'Comparative study on Discrimination against Persons with HIV or AIDS' Swiss Institute of Comparative Law, Lausanne, Switzerland, 1993 at 31.

11.6.5 Evaluation and recommendation

The Commission recommends that -

- **A child of at least 12 years of age should have the right not to have information regarding the outcome of his or her HIV test disclosed.**
- **A child under 12 years of age who is of sufficient maturity to understand the benefits, risks and possible social implications of an HIV test should have the right not to have information regarding the outcome of his or her HIV test disclosed.**
- **The HIV status of a child under 12 years of age who is not of sufficient maturity to understand the benefits, risks and possible social implications of an HIV test may only be disclosed by other parties on a need-to-know basis when it is in the best interests of that child or when the child's HIV/AIDS status would pose a real risk to third parties.** The Commission did not debate the meaning of a 'real risk' and invites comment in this regard. The disclosure of a child's HIV/AIDS status should not affect the child's right to education and the right to play and should not be capable of being lawfully raised as an impediment to the general overall care of the child.
- **All child care practitioners, including medical practitioners, should have a legal duty to consider the possible consequences of disclosure of information regarding a child's health status before providing this information to third parties.**
- **Before disclosing a child's HIV status, note must be taken of the National Policy on testing for HIV.**

11.7 Access to contraceptives

11.7.1 Introduction

In order for young persons to make informed choices regarding the age of initiating sexual activity, and protecting themselves against unwanted pregnancies and sexually transmitted diseases, they need access to appropriate family planning services. This raises a number of issues relating to the age at which they may utilise such services and the family and parental involvement in this process.

11.7.2 **South African Law and Policy**

A child is entitled to consent to medical treatment on their own if over the age of 14. This has led the Department of Health to adopt a policy of providing contraceptives to children over the age of 14 without informing parents or requiring parental consent. With children 14 years and younger, contraceptives will only be provided once the health care worker has considered the individual circumstances of the child. However, many children 14 years and younger are sexually active, and making provision of contraceptives subject to the discretion of a health care worker tends to make such services inaccessible.

11.7.3 **Comparative review of systems in other countries**

The Reproductive Health Services Policy in Ghana provides that services must be provided to adolescents and that this includes all couples engaging in sexual activity, regardless of age.⁸⁰

The Tanzanian family planning guidelines state that all males and females of reproductive age, including adolescents, are entitled to family planning information, education and services. They are also entitled to counselling and those who are sexually active may request counselling on access and methods of family planning which will suit their individual circumstances.⁸¹

80 'Women of the World: Laws and Policies affecting their reproductive lives' Anglophone Africa Centre for Reproductive Law and Policy 1997 at 85 - 86.

81 Ibid at p. 126.

In California, a minor may consent to medical care related to the prevention or treatment of pregnancy without the assistance of their parent or guardian.⁸² In other words, a minor of any age is entitled to have access to contraceptives.

11.7.4 **Comments received**

The research paper asked respondents to comment on the following recommendation:

It is recommended that the consent provisions in the Child Care Act should provide an exception to the consent rules with regard to access to contraceptives. It is proposed that this should follow the Ghanaian and Californian examples and provide that access to contraceptives should be provided to all sexually active couples regardless of age.

The respondents welcomed this recommendation. Some, however, felt that cognisance should be taken of the spiritual and moral aspects of the family as the welfare of the child also includes certain spiritual and moral issues. The HIV/AIDS Project Committee submitted that more debate may be needed to support the recommendation regarding supply of contraceptives regardless of age.

11.7.5 **Evaluation and recommendation**

Following the Ghanaian and Californian approach, the Commission recommends that confidential access to contraceptives should be provided to all sexually-active persons, regardless of age. The Commission further recommends that access to contraceptives and advice about contraceptives should be at state expense where necessary and should not be linked to medical treatment.

11.8 **Access to termination of pregnancy services**

11.8.1 **Introduction**

82 Section 6925(a) of the Californian Family Code.

In South Africa the 'law against abortion' has been radically altered by the Choice on Termination of Pregnancy Act 92 of 1996. Under this Act the focus of the law has shifted away from 'abortion', with its connotation of criminality, to a woman's right of choice with respect to reproduction, including the right to choose to terminate a pregnancy in the early part of the gestation period. Prior to this development in our law, South African common law permitted lawful abortion only in the case of necessity, the only clear instance of which was to save the mother's life. Some measure of reform was introduced by way of the Abortion and Sterilisation Act 2 of 1975.⁸³

11.8.2 South African Law and Policy

Under the Choice on Termination of Pregnancy Act 92 of 1996 the grounds for lawful termination of pregnancy are dependent on the gestation period. The most significant change introduced by this Act is that a pregnancy may be terminated at the request of a pregnant woman during the first 12 weeks of the pregnancy.⁸⁴ No other grounds for lawful termination are required during this period. The consent of the pregnant woman is sufficient to secure a termination, even if she is a minor.⁸⁵ Where the pregnant woman is a minor, the medical professional concerned is only under an obligation to advise her to consult with her parents, guardian, family or friends before the pregnancy is terminated. The termination may not be denied should she choose not to consult with such persons.⁸⁶ Terminations during the first 12 weeks may be carried out by a registered midwife who has completed a prescribed training course.

From the 13th week to the end of the 20th week of pregnancy a termination may be carried out on grounds broadly approximating those set under the Abortion and Sterilization Act of 1975: (a) the continued pregnancy poses a risk of injury to the woman's physical or mental health; (b) there is a substantial risk that the foetus would suffer from a severe physical or mental abnormality; (c) the pregnancy is the result of rape or incest; or (d) the continued pregnancy would significantly affect

83 This Act was repealed by the Choice on Termination of Pregnancy Act 92 of 1996 in so far as it relates to abortion.

84 Section 2(1)(a). This effectively introduces abortion on demand during the first 12 weeks of pregnancy.

85 Section 5. Informed consent is required.

86 Sections 5(4) and (5) make special provision for terminations in respect of women who are severely mentally disabled or in a state of continuous unconsciousness.

the social or economic circumstances of the woman.⁸⁷ A medical practitioner must, after consulting with the pregnant woman, be of the opinion that one of the grounds exists before carrying out a termination during this period.

87 Sections 2(1)(b)(i) - (iv) respectively. The fourth ground, viz the effect of the pregnancy on the social and economic circumstances of the woman, is entirely new. See also J Birenbaum 'Contextualising choice: Abortion, equality and the right to make decisions concerning reproduction' (1996) 12 **SAJHR** 485.

After the 20th week of the gestation period the grounds for termination are limited to: (a) endangerment of the woman's life; severe malformation of the foetus, or (c) risk of injury to the foetus. Here the medical practitioner concerned must consult with another medical practitioner or with a registered midwife before forming an opinion that one of the grounds for termination exists. In all cases of termination, at whatever stage of the gestation period, the informed consent of the pregnant woman is required.⁸⁸

The Choice on Termination of Pregnancy Act 92 of 1996 has come under constitutional attack in **Christian Lawyers Association of SA v Minister of Health**.⁸⁹ The plaintiffs in this case argued that the whole of the Act be struck down as unconstitutional on the basis of the argument that the right to life⁹⁰ applies to an unborn child. The matter was decided on exception, the defendants arguing that the plaintiff's case disclosed no cause of action. In its judgment the Transvaal High Court held that the validity of the plaintiff's cause of action depended on the legal (as opposed to religious or philosophical) question whether the term 'everyone' in section 11 of the Constitution applied to an unborn child. In finding that it did not so apply, the court was persuaded by the fact that, despite the possible uncertainty existing at common law, the Constitution made no express provision affording legal personality or protection to the foetus. The court recognised that if it were to accept that section 11 of the Constitution safeguarded the right to life of a foetus, this would mean that the foetus would enjoy the same protection as the mother. This would have far-reaching consequences which, in the absence of a clear expression of intention in this regard, could not have been contemplated by the drafters. The court accordingly held that '... under the Constitution the foetus is not a legal *persona*'.

Apparently, the Christian Lawyers Association has instituted action in the High Court of Pretoria against the Minister of Health, the Premier and MEC for Health of Gauteng to challenge section 5 of the Choice of Termination of Pregnancy Act 92 of 1996. The Association, inter alia, argues that the

88 Van Heerden et al **Boberg's Law of Persons and the Family** (2nd edition) 45.

89 1998 (4) SA 1113 (T).

90 Section 11 of the Constitution.

provisions of the Act which allow termination of pregnancy without parental consent are infringing the child's right to parental care in terms of 28 of the Constitution.

11.8.3 Evaluation and recommendation

The Commission has recommended that the new children's statute should not apply to unborn children.⁹¹ From our perspective, and given the focus of this discussion paper, **the Commission accepts that a woman, even a girl child, has a right of choice with respect to reproduction, including the right to choose to terminate a pregnancy.** However, we do acknowledge the absurdity of the situation where a (girl) child of any age can have an abortion without parental consent in terms of the Choice on Termination of Pregnancy Act 92 of 1996, but needs parental consent to undergo any other operation in terms of section 39 of the Child Care Act, 1983.

11.9 The right to refuse medical treatment

11.9.1 Introduction

The advances made in medical science and in the application of medical technology have resulted in patients living longer. For many patients this signifies a welcome prolongation of meaningful life, but for others the result is a poor quality of life which inevitably raises the question whether treatment is a benefit or burden.⁹² The need has therefore arisen to consider the protection of a child's right to refuse medical treatment. This section draws a distinction between two scenarios namely, (a) where a child or he or her parents refuse treatment due to the child's health condition being such as to preclude an acceptable quality of life, and (b) where treatment for the child is refused based on religious beliefs.

11.9.2 South African Law and Policy

91 See the definition of 'child' in 4.2 above.

92 South African Law Commission **Report on Euthanasia and the Artificial Preservation of Life** November 1998 at 2.

Patients have a common law right to refuse medical treatment.⁹³ Strauss⁹⁴ puts it as follows:

Our law allows a person to refuse medical treatment or a particular form of treatment, even if that may result in the patient's health deteriorating.

93 Strauss **Doctor, Patient and Law** at 31.

94 Ibid.

Whilst the common law position for adults is clear and unambiguous, the Child Care Act has changed the position for children. The Act provides that if a parent or guardian refuses his or her consent to an operation or treatment, and the medical practitioner believes the treatment or operation is necessary, then he or she may report the matter to the Minister of Social Development who may authorise the treatment or operation if satisfied that it is necessary.⁹⁵

There are several problems with section 39(1) relating to the right of a parent or guardian to refuse medical treatment on behalf of their minor child. In essence the problems are that the current Act does not take into account the following:

- that the views of parents or guardians of children infected with HIV should be involved in decisions regarding the type of care their children receive; and
- children or young adults who are at the age where they may lawfully consent to medical treatment should be entitled to participate in decision-making regarding their health.

The South African Law Commission in its Report on Euthanasia and Artificial Preservation of Life, 1998, stated that although a child over the age of 14 may consent to medical treatment without the assistance of his or her guardian, that the right to refuse medical treatment *without assistance* should be limited to persons above 18 years as a safety measure since refusal of treatment could be to the detriment of the patient. The Commission is of the view that there is a rational distinction to be made between giving consent and withholding consent and that it is right for the law to be reluctant to allow a child to veto treatment designed for his or her benefit, particularly if a refusal will lead to the child's death or permanent damage. The Commission therefore recommended that every child above the age of 14 until the age of 18, of sound mind and *assisted by his or her parents or guardians*, is competent to refuse any life-sustaining medical treatment or the continuation of such treatment with regard to any specific illness from which he or she may be suffering.

95 Section 39(1) of the Act.

11.9.3 **Comparative review of systems in other countries**

In a recent English case the Appeal Court held that the best interests of every child include an expectation that difficult decisions affecting the length and quality of their life will be taken by their parents.⁹⁶ Furthermore, in England the Children's Act, 1989, provides that a child with sufficient understanding of the procedure or treatment may refuse life-extending treatment.⁹⁷ This position has, however, been eroded by court decisions which have held that a court has the inherent jurisdiction in such matters and may override such decisions by children.⁹⁸

In Zimbabwe, as stated in 11.4.3 above, if consent is refused by the parent or guardian, the medical practitioner may apply to the local magistrate for consent to undertake the procedure.⁹⁹

11.9.4 **Comments received**

The research paper asked respondents to comment on the following recommendation:

It is recommended that the consent legislation should follow the Zimbabwean approach where a court application must be made to a local magistrate if a parent or guardian's decision is to be overridden. It is therefore proposed that the consent provisions within the Child Care Act be amended to provide that should a parent or guardian refuse to give their consent for medical treatment or an operation and a medical practitioner believes such treatment is necessary then an application must be made to the Commissioner of the Children's Court for a decision regarding consent. At such a hearing the following parties should be provided with an opportunity to state why they believe the proposed procedure should or should not take place: the parents or guardians, the child affected and the medical practitioner. A decision should then be taken on the basis of the 'best interests of the child'

96 **The Weekly Telegraph** 30 October 1996.

97 Sections 38(6), 43(8), and 44(7) quoted in **AIDS : a Guide to the Law** at 5.

98 See **Re W** (1992) 4 All ER 627 and **South Glamorgan Country Council v W and B** (1993) 1 FLR 574 quoted in **AIDS : a Guide to the Law** at 5 - 6.

99 Section 76(1) of the Children's Protection and Adoption Act.

principle and the clinical information provided.

The majority of respondents agreed with the recommendation made. Referring to the issue of religious belief which may prevent treatment, the NICC argued that limitations need to be set to customary rights as the Child Care Amendment Act does give rights to consent for medical treatment for the child.

On the other hand, the Jehovah Witnesses of South Africa submitted that Jehovah Witnesses' children should not have to undergo blood transfusion and that they should receive a medically accepted alternative choice, namely non-blood medical and surgical management. Also, if the treatment is not urgent, notice must be given to the parent should the consent of the Minister be required in terms of section 39(1). Notice should also be given in those circumstances contemplated in section 39(2) in that the superintendent must give notice to the parents if their whereabouts are known. The respondent submitted that consideration should be given to the concept of mature minor. Thus, if a minor is competent enough to make decisions about his or her health, the court must accept the views of that minor regardless of his or her age. The respondent suggested that the following be taken into account in the event the court feels compelled to issue a court order to permit the use of blood: (a) should the order limit when and how blood might be used? For example, doctors have been required to use or consider the use of non-blood medical alternatives first and to record in the child's clinical notes why blood was deemed necessary, (b) should the order require that senior doctors more experienced in non-blood management make the clinical decision if and when blood is to be given?, (c) should the order be restricted specifically to the use of blood only? Since it is only blood that the parents are refusing, there is no need to take all medical decision-making authority away from them, and (d) should a time limit be put on the order showing a specific expiration date or time for traditional re-examination?

11.9.5 **Evaluation and recommendation**

The Commission recommends as follows:

The Commission reaffirms the view it took in the Report on Euthanasia and Artificial Preservation of Life and recommends that every child above the age of 12 years, of sound mind and assisted by his or her parents or guardian, is competent to refuse

any life-sustaining medical treatment or the continuation of such treatment with regard to any specific illness from which he or she may be suffering.

- **That the Children’s Court may be approached if a child above the age of 12 years and of sound mind disagrees with his or her parent or guardian that medical treatment on him or her should be refused or discontinued or where a medical practitioner believes that such treatment is necessary.**
- **That no child may be deprived of medical treatment by reason only of religious or other beliefs unless the person who refuses to give consent can show that there is a medically accepted alternative choice.¹⁰⁰**

C:\Documents\CCareDPchapters\Chapter11Healthrights.wpd

100 See 11.2.5 above where it is proposed that a child should have the right to use alternative health care systems if so desired. See also 23.10.4 below.