CHILDREN'S ACT GUIDE
for Health Professionals

December 2013 **Fifth Edition**

Lucy Jamieson and Lori Lake

Children's Institute, University of Cape Town

10 years child rights in focus
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SUMMARY OF FORMS

These forms are required in terms of the Children's Act. This guide explains how and when they should be used. All forms are reproduced in full at the end of the guide.

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Form 22	Reporting of abuse or deliberate neglect of a child
Form 29	Inquiry by employer to establish whether person's name appears in Part B of NCPR
Form 33	Application for consent to medical treatment or surgical operation by the Minister
Form 34	Consent to surgical operation by a child
Form 35	Consent to surgical operation of a child by a parent

ACRONYMS

CTOP	Choice on Termination of Pregnancy
DCPO	Designated Child Protection Organisation
DOJ&CD	Department of Justice and Constitutional Development
DSD	Department of Social Development
FCS	Family Violence, Child Protection and Sexual Offences Unit
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
NHA	National Health Act
STI	Sexually-Transmitted Infections
TOP	Termination of Pregnancy
UN	United Nations
UNCRC	United Nations Convention on the Rights of the Child

KEY WORDS

Key terms	Definition
Abandoned	A child is abandoned if he or she has been deserted by the parent, guardian or caregiver, or if he or she has not had contact with the parent, guardian or caregiver for at least three months for no apparent reason.
Abuse	Abuse means any form of harm or ill-treatment deliberately inflicted on a child. It includes: • assaulting or deliberately injuring a child; • sexually abusing a child or allowing a child to be sexually abused; • bullying by another child; • a labour practice that exploits a child; or • exposing or subjecting a child to behaviour that may harm him or her psychologically or emotionally.
Alternative care	A child is in alternative care if he or she has been placed by a court in temporary safe care, a child and youth care centre or foster care.
Caregiver	A caregiver is anyone who cares for a child. Caregivers include: • grannies, aunts and other relatives who care for the child with the consent of the child's parents or guardian; • a foster parent; • someone offering temporary safe care; • the head of a shelter or child and youth care centre; • a child and youth care worker supporting children in the community; and • a child (of 16 years and older) heading a child-headed household.

Child(ren) in need of care and protection	Section 150 of the Children's Act says the government has to take action to protect children who are in need of care and protection, which includes a child who: • has been abandoned or orphaned and does not have any visible means of support; • displays behaviour that cannot be controlled by the parent or caregiver; • lives or works on the streets or begs for a living; • is addicted to substances that cause dependency and does not have any support to get treatment for his or her addiction; • has been or is at risk of serious physical or mental harm; or • has been abused, neglected, or exploited. If a child is found to be a victim of child labour or is living in a child-headed household, a social worker must investigate to find out if the child is in need of care and protection.
Designated child protection organisation	A child protection organisation that has been given written approval by the Director-General or provincial Head of Social Development to perform child protection services.
Designated social worker	A designated social worker is any social worker who works for the Department of Social Development, a municipality or a designated child protection organisation. There are many times when the Children's Act says that a certain task should be done only by a designated social worker.
Exploitation	To exploit children is to take advantage and treat them unfairly. Children can be exploited in different ways. Child pornography and child prostitution are examples of sexual exploitation. Child labour and using children to commit crimes are examples of economic exploitation.[1]
Neglect	A child is said to have been neglected when the caregiver has not fulfilled his or her basic parental responsibilities. According to the Children's Act, these responsibilities are "to provide for the basic physical, intellectual, emotional or social needs" of the child.

[1] Wright JH (2006) *What is child exploitation?* http://ezinearticles.com

Orphan	An orphan is a child who has no surviving parent caring for him or her.
Parent	Includes adoptive parent.
Person who has rights and responsibilities in respect of the child	The child's parent, guardian or caregiver is a person who has rights and responsibilities in respect of the child. It is important to note that generally caregivers do not have the full range of parental rights and responsibilities, and they must consult with a parent or guardian before making major decisions. Sometimes even certain parents do not enjoy full parental responsibilities and rights in respect of a child (e.g. one parent could have a right of contact only while the other parent has guardianship over the child).
Prescribed	If something is prescribed, it means it is required by law. For example, the forms contained in the Regulations of the Children's Act are prescribed – that is, they are the legally required forms that must be completed for particular purposes.
Sexual abuse	In relation to a child, sexual abuse means: • sexually molesting or assaulting a child, or allowing a child to be sexually molested or assaulted (subjecting the child to unwanted or improper sexual activity, for example, by touching or the child on his or her private parts); • encouraging, inducing or forcing a child to be used for the sexual gratification of another person; • using a child in, or deliberately exposing a child to, sexual activities or pornography; or • giving a child, or anyone else, money or other rewards for the child to perform sexual activities including prostitution and pornography; or • allowing anyone else to sell the sexual services of children.

1 WHO IS THIS GUIDE FOR?

The guide is written for health and allied professionals, and it focuses on the parts of the Children's Act that are most relevant to them. This is an updated edition of the 2010 guide and contains extra information on children's rights and the responsibilities of health professionals. It also has updated information on developments in the law and in government policy that impact on provision of health services.

All health professionals are required to perform their duties and responsibilities according to the Children's Act when working with children. It is therefore essential for health professionals to have thorough knowledge of this law.

This guide is not meant to replace the Children's Act. Instead, it should be read together with a copy of the Act itself. All health professionals responsible for the care and development of children are strongly encouraged to study the Act and attend a training course on it, in order to grapple with the complexities of applying the provisions of the Act in different contexts.

To obtain a copy of the Act, its Regulations and the latest versions of its forms, visit **www.ci.org.za.** Contact Bee Williams on 021 689 5404 to find out about Children's Institute training for health professionals.

2 WHAT IS THE CHILDREN'S ACT?

The Children's Act replaces the Child Care Act and is a law which governs the provision of a range of services for children and families. The aim of the Act is to support families to enable them to ensure their children's well-being, to prevent the **abuse** and **neglect** of children, and to ensure that **children in need of care and protection** are provided with appropriate care.

The social services governed by the Act include:

- early childhood development programmes and partial care services;
- prevention and early intervention programmes (including home-based care for families affected by chronic illnesses such as HIV/AIDS; parenting programmes; child and family counselling; and providing families with the basic necessities);
- drop-in centres (which offer vulnerable children basic services such as food and assistance with personal hygiene);
- protection services (these involve identifying, reporting and supporting abused and vulnerable children);
- foster care and cluster foster care;
- adoption; and
- child and youth care centres (children's homes, schools of industry, places of safety and shelters for street children).

Abuse: Abuse means any form of harm or ill-treatment deliberately inflicted on a child. It includes: assaulting or deliberately injuring a child; sexually abusing a child or allowing a child to be sexually abused; bullying by another child; a labour practice that exploits a child; or exposing or subjecting a child to behaviour that may harm him or her psychologically or emotionally.

Neglect: A child is said to have been neglected when the caregiver has not fulfilled his or her basic parental responsibilities. According to the Children's Act, these responsibilities are "to provide for the basic physical, intellectual, emotional or social needs" of the child.

Children in need of care and protection: Section 150 of the Children's Act says the government has to take action to protect children who are in need of care and protection, which includes a child who: has been abandoned or orphaned and does not have any visible means of support; displays behaviour that cannot be controlled by the parent or caregiver; lives or works on the streets or begs for a living; is addicted to substances that cause dependency and does not have any support to get treatment for his or her addiction; has been or is at risk of serious physical or mental harm; or has been abused, neglected, or exploited.

If a child is found to be a victim of child labour or is living in a child-headed household, a social worker must investigate to find out if the child is in need of care and protection.

In addition, the Children's Act regulates who provides these services and how they go about it. The Act does so by identifying who should provide the services and by setting out the norms and standards for the services.

The original Children's Act 38 of 2005 was amended by the Children's Amendment Act 41 of 2007. Some of the provisions came into force on 1 July 2007, and the rest of them — along with their associated Regulations — on 1 April 2010.

2.1 Who does the Children's Act apply to?

The Act applies to:

- individuals (**parents**, guardians or **caregivers** of children, as well as people working with children);
- civil society organisations;
- companies; and
- all organs of the state.

Organs of state are government departments and institutions such as clinics and hospitals and the people who work for government, such as nurses, doctors, educators, social workers and other officials.

Parent: Includes adoptive parent.

Caregivers: A caregiver is anyone who cares for a child. Caregivers include: grannies, aunts and other relatives who care for the child with the consent of the child's parents or guardian; a foster parent; someone offering temporary safe care; the head of a shelter or child and youth care centre; a child and youth care worker supporting children in the community; and a child (of 16 years and older) heading a child-headed household.

2.2 Why did South Africa reform the law on consent to health treatment for children?

The Child Care Act[2] provided that children above the age of 14 could consent to medical treatment and children between the age of 18 and 21[3] could consent to surgical operations. For medical treatment for children under 14 years, or surgery for children under 18 years, consent needed to be obtained from their biological parents or legal guardians. When it was not possible to obtain consent from parents or legal guardians, a report had to be sent by a social worker to the Minister of Social Development, who was authorised to give consent.

As a result of the HIV pandemic and urban migration, there are many children who are not cared for by their parents or legal guardians but by relatives, neighbours or other caregivers. The Child Care Act did not provide sufficient flexibility to meet the needs of children in these situations and as a result children's access to health care services was limited. The old law also failed to explicitly recognise and pro-actively promote the child's right to participate in decisions that affected his or her health. Furthermore, HIV testing and confidentiality were not dealt with adequately in the Child Care Act. Research showed that children were becoming sexually active at a younger age and that the age threshold of 14 years therefore needed to be lowered to ensure that children could access reproductive health care services including counselling. Academics also noted that the age threshold for consent to surgery was unreasonable as research (national and comparative) indicated that children younger than the age of 18 were capable of consenting to surgery.[4]

A new law was therefore necessary to fully recognise the rights of the child to participate in decisions affecting them, clarify their right to privacy in respect of disclosure of HIV status, lower the age of consent to promote access to health care services, and allow caregivers (e.g. grannies and aunts) to consent to health treatment for young children in their care.

2.3 Implementation of the Act – conflicts with other laws and policies

Where there is a conflict between the Children's Act and another Act of Parliament such as the Sexual Offences Act, the health professional must be guided by the general principles of the Children's Act when making a decision on how to proceed.

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[2] The Child Care Act no 74 of 1983.

[3] When the Child Care Act was promulgated the age of majority was 21. The Children's Act reduced the of majority to 18.

[4] C Ngwena (1996) Health care decision making and the competent minor: the limits of self-determination. *Acta Juridica* 132.

Where there is a conflict between the Children's Act, provincial legislation; municipal by-laws; policies, guidelines or codes of conduct the Children's Act prevails. For example, the Children's Act allows a child younger than 12 to consent to an HIV test and the disclosure of their HIV status. However, section 13 of the Ethical Rules of Conduct for Practitioners registered under the Health Professions Act[5] allows a health provider to disclose health information (which could include the results of an HIV test) with the consent of a parent where the child is under 12. In other words the code gives the parent (and not the child) the right to consent to the disclosure of such information. See section 13(2)(b) of the Rules. In this case the Children's Act takes precedence and the child under 12 has a right to refuse to the disclosure of such information and the health provider should act in accordance with the consent or refusal of the child (and not that of the parent).

2.4 Children's rights in the Children's Act

The Act aims to make sure that children's constitutional rights are made a living reality, in particular, children's rights to:

- family care, parental care or appropriate **alternative care** when the child has been removed from the family environment;
- social services;
- protection from maltreatment, neglect, abuse or degradation; and
- the right to have the child's best interests put first in every matter concerning him or her.

How does the Act work to make children's rights a reality?

- It strengthens the rights they already have under the Constitution of South Africa and in international law.
- It also introduces new rights, such as the right of children to participate in decisions affecting them.
- Where there is a right, there is a corresponding duty and responsibility.
- Everyone working with children must respect, protect, promote and fulfil the rights set out in the Children's Act.

Alternative care: A child is in alternative care if he or she has been placed by a court in temporary safe care, a child and youth care centre or foster care.

[5] *Government Gazette* 29079, Government Notice R717, 4 August 2006 as amended by *Government Gazette* 31825 Government Notice R68, 02 February 2009.

These people have a duty to:

- **Respect children's rights**. People must not interfere with children's enjoyment of their rights. For example, all people who work with children must respect children's right to be free from violence by not smacking them.

- **Protect children's rights.** The government must take active steps to prevent other people from interfering with (or violating) children's rights. For example, the government must run programmes to prevent people from abusing children. Similarly, anyone caring for children must protect them from abuse.

- **Promote and fulfil children's rights**. The State must take action and put programmes in place to make these rights a reality. For example, the State must provide prevention and early intervention programmes to fulfil children's rights to protection from abuse.

2.5 Putting the Children's Act into practice

It is important to see the Children's Act as a living document that will change over time in order to meet children's needs in the best way possible.

The Act took more than 10 years to write and put into practice. During this time, the context in which children live and in which services are delivered has changed. For example, the number of **orphans** has grown. The Act was not designed to meet this particular challenge, so certain parts of it need to change. What's more, some of the services in the Act are new and being implemented for the first time. As a result, you might come across things in it that do not work well in practice.

This is par for the course with any new law, and at the time of writing this guide the Department of Social Development (DSD) was talking to a range of stakeholders to find out their experiences and what changes they recommend in the Children's Act. These changes will be outlined in an Amendment Bill that the DSD hopes to take to Parliament after the elections in 2014.

TAKE ACTION

Write down any challenges you experience in implementing the Act as well as suggestions you have for improving it. Contact Lucy Jamieson at the Children's Institute for information on how to make a submission to the Department of Social Development.

Orphan: An orphan is a child who has no surviving parent caring for him or her.

3 WHY IS THE CHILDREN'S ACT IMPORTANT FOR HEALTH PROFESSIONALS?

The Children's Act is a "one-stop-shop" law that covers a huge range of matters affecting children. Because of this, it has repealed a number of older laws that used to deal with children. These include the:

- Child Care Act of 1983;
- Children's Act of 1960;
- Age of Majority Act of 1972;
- Children's Status Act of 1987;
- Guardianship Act of 1993;
- Natural Fathers of Children born out of Wedlock Act of 1997; and
- Section 4 of the Prevention of Family Violence Act of 1993.

In order to promote children's rights and well-being, the Children's Act provides a legal framework to guide people who are involved in the care, development and protection of children on the actions and steps they must take to secure children's rights. Among other things, the Act:

- states what the rights of children are;
- outlines the general principles that must be applied by anyone interacting with a child;
- states when a child can consent to medical treatment, surgical operations, HIV testing and disclosure;
- states who can consent when a child lacks legal capacity;
- states at what age a child can access contraceptives;
- defines a caregiver;
- defines a child in need of care and protection; and
- creates mandatory reporting requirements in respect of abuse and neglect.

All health professionals are required to perform their duties and responsibilities according to the Children's Act when working with children. It is therefore essential for health professionals to have thorough knowledge of this law.

4 WHAT ARE THE RIGHTS INFORMING HEALTH CARE PRACTICE?

Justice Albie Sachs in his judgment on S v M reminds us that all children are individuals with the full array of human rights and that adults must respect children's inherent dignity and allow them to grow through experience.

> *If a child is to be constitutionally imagined as an individual with a distinctive personality, and not merely as a miniature adult waiting to reach full size, he or she cannot be treated as a mere extension of his or her parents, umbilically destined to sink or swim with them. The unusually comprehensive and emancipatory character of section 28 presupposes that in our new dispensation the sins and traumas of fathers and mothers should not be visited on their children.*
>
> *Individually and collectively all children have the right to express themselves as independent social beings, to have their own laughter as well as sorrow, to play, imagine and explore in their own way, to themselves get to understand their bodies, minds and emotions, and above all to learn as they grow how they should conduct themselves and make choices in the wide social and moral world of adulthood.*[6]

The recognition that children are holders of rights is central to the philosophy and implementation of children's rights. Children are not merely passive recipients of adult care and protection. Rather, they are social actors entitled to contribute to the exercise of their rights and to participate in decisions that affect them. Such an approach has profound implications for the relationships between children and health professionals, and indeed between children and their parents.

In particular, health professionals need to consider children's rights:

- to have their best interests prioritised;
- to participate, to be listened to and to have their views taken seriously and to have their evolving capacities considered;
- to information and health education;
- to freedom and security of the person;
- to protection from abuse and neglect;
- to privacy and confidentiality;
- to equality and non-discrimination;

[6] *S v M* (Centre for Child Law as Amicus Quarie) [2007] ZACC 18; 2008 (3) SA 232 (cc); 2007 (12) BCLR 1312 (CC) (S v M). Paras 18-9.

- to parental guidance;
- to family care and parental care; and
- to social services.

Four of the rights in the United Nations Convention on the Rights of the Child (UNCRC) are highlighted as general principles that must inform everything we do for children. They are: survival and development; participation; non-discrimination; and the child's best interests.

4.1 The best interest of the child

The importance of considering the best interests of the child in all matters that affect the child is recognised in both the UNCRC and the African Charter on the Rights and Welfare of the Child. The Constitution notes that *"a child's best interests are of paramount importance in every matter concerning the child".* This includes matters affecting the health and well-being of the child. The Children's Act stipulates further that the best interest standard must be applied in all matters concerning the protection, care and well-being of the child. Thus in all decisions, actions and proceedings regarding the health and well-being of children the best interest standard must be applied.

4.2 The right to participate, to be listened to and to be taken seriously

All children capable of expressing a view are entitled to express that view on all matters affecting them and to have their views given due regard in accordance with the age and maturity of the child. This principle places a clear obligation on adults to listen to children and consider what they say seriously. It is important to understand the implications of this right.

All children are capable of forming a view. Even very young children can express their views, fears, concerns and outrage, and article 12 of the UNCRC requires that adults create the time and be willing to hear those views and give them respect. The extent to which they are able to fulfil the child's wishes will depend on the issue, the choices available, their implications and the child's capacity to understand the issue. But a child's view is not invalid simply because of his or her youth: a baby, as well as a 16-year-old, has a right to be listened to. But it may be necessary to explore different ways to enable younger children to express and articulate their concerns.[7]

[7] Alderson P, Hawthorne J & Killen M (2005) The participation rights of premature babies. *International Journal of Children's Rights,* 13(1): 31-50.

All children are entitled to views on all matters affecting them. Article 12 of the UNCRC (as well as section 10 of the Children's Act) covers all aspects of children's lives. Whether it is decisions within the family, in school, in the hospital or in matters of public policy, children are entitled to be consulted and involved. It is important to recognise that many decisions traditionally taken by adults have an impact on children, for example, the location and design of a hospital, the way in which clinics are organised, the management of hospital wards, or policies regarding sexual and reproductive health. These are all areas where children, and their parents, can make a useful contribution if properly consulted.

What are the benefits of children's participation in health care decision making?

There are a number of benefits in involving children in their own health care:

It makes children feel more respected. When children feel that they are respected, listened to and that their views are valued and taken seriously, this helps ease the vulnerability associated with being ill, in pain and dependent on others.

It relieves anxieties and helps them better cope with treatment. If children have information about their condition, they are better able to cope with what is happening to their bodies and to understand why things are happening the way they are.

It gives them confidence. If children are involved in the process of treatment, then they will not fear that actions will be taken without their knowledge or understanding.

It encourages co-operation. If children lack information, they are likely to be more frightened and therefore less willing or able to co-operate in treatment which, in turn, makes interventions more painful and distressing.

It avoids unnecessary distress. When information is withheld, children may worry unnecessarily about what is going to happen to them. Often the imagined risks are far worse than reality. If they have information, children can prepare appropriately for what is happening and receive the necessary counselling, comfort and/or support.

Children develop a better understanding of their own health care needs, and are better able to take responsibility for their own health.

All children are entitled to have their views given due regard. There is little point in listening to children if there is no commitment to consider what they say. This means being prepared to create the time to hear what children think and feel, and to give serious consideration to what they say. This does not mean there is an obligation to always comply with a child's wishes – but their views should not be dismissed simply because they are young or because they do not coincide with those of the adults involved.

The weight given to a child's views will depend on his or her age, maturity and level of understanding of the issue. This does not simply mean that older children's views will be given more weight. There is clear evidence, for example, that young children who have experienced major surgery and frequent medical interventions, can have a profound understanding of the life and death implications of choices affecting them and are capable of making choices if properly supported by adults around them. The onus lies with the health professional to support the child and to build the child's capacity for health decision-making through a process of dialogue. The more competent a child, the more emphasis should be placed on his or her wishes and views.

4.3 The child's right to respect for their evolving capacities

The UNCRC stresses that parents have the right and responsibility to provide direction and guidance to their children. However, such guidance must be directed to the promotion of the child's rights and be provided *"in a manner consistent with the evolving capacities of the child."*[8]

This principle [evolving capacity] in international law – has profound implications for the human rights of the child. It recognises that as children grow and develop increasing competencies, they require less adult direction and support and have a greater capacity to take responsibility for decisions affecting their lives. The UNCRC recognises that children acquire these competencies at different ages depending on their environment, culture and individual life circumstances.

> *The concept of evolving capacities is central in achieving a balance between recognising children right to be listened to and granted increasing autonomy, and recognising their right to protection and support in accordance with their relative immaturity and youth. "This concept provides the basis for an appropriate respect for children's agency without exposing them prematurely to the full responsibilities normally associated with adulthood". [9]*

[8] Article 5.

[9] Lansdown G (2005) *The Evolving Capacities of the Child*. UNICEF Innocenti Research Centre, page ix.

In many countries, consent procedures are often **prescribed** in law and pegged at a fixed age. For example, the old Child Care Act, said that children acquired the competence to make informed decisions about health care at 14. This is not in line with an approach based on evolving capacities. The evolving capacities approach requires doctors to progressively involve children more fully in decisions relating to their health; to help parents recognise the importance of respecting children's active involvement; and to encourage an approach to decision-making which is open, participative and informed. The new Children's Act has lowered the age threshold to 12 and introduced a maturity test which helps to bring South African law more in line with the concept of evolving capacity as it requires an assessment of, and respect for, each individual child's maturity.

4.4 The right to information

The UNCRC and Children's Act include an obligation to ensure that children and their parents (and the community) have access to education and information to enable them to achieve the best possible health. Access to health promoting information can play an important role in protecting children by enhancing their capacities to make informed decisions. Health professionals can play a key role in ensuring that children and their parents have the necessary knowledge and skill to make positive choices and live healthy lives.

These health provisions imply that health professionals should:

- provide information to help children to understand how they can lead healthy lives (e.g. information about sexual reproductive health, HIV/AIDS, nutrition, smoking, alcohol, illegal drugs, physical and psychological development);
- develop preventative and promotional materials in child-friendly formats that are age-appropriate and easy for children to understand (which is best done in partnership with children themselves);
- ensure that child patients receive information in a format that allows them to fully understand their own health status and treatment options; [10]
- work collaboratively with parents and children to foster an understanding and respect for their respective rights and responsibilities with regard to decision-making in relation to the child's health; and
- advise children where they can go for further information and help.

Prescribed: If something is prescribed, it means it is required by law. For example, the forms contained in the Regulations of the Children's Act are prescribed – that is, they are the legally required forms that must be completed for particular purposes.

[10] This is also a requirement of section 6(2) of the National Health Act (61 of 2003).

The way information is given is crucial:

- it must be given in ways that are age-appropriate and consistent with the child's level of understanding;
- it must be given in a language which the child understands;
- it should preferably be provided by someone whom the child knows and trusts;
- time must be made available to enable the child to ask questions both immediately and after any treatment and time to consider the potential consequences, risks and benefits of more complex procedures; and
- the child needs to feel safe and confident that his or her concerns will be taken seriously when decisions are being made.

Parents should be as fully involved as possible, so that they understand the treatment options and procedures, and so that they can support and reassure the child. Parents may also be able to translate medical information into a language that younger children can understand and support older children when making decisions about surgery. However, older teens may prefer to maintain their independence and privacy; and are entitled to give consent to medical treatment, HIV testing and access to contraception independently.

Taken together these rights place an obligation on health professionals to:

- explore with children (and their caregiver/s) their treatment options, their level of understanding, their associated opinions and views (and only then can they assess children's competence to make decisions about their treatment and care);
- present information to children in a ways they will understand and that are appropriate to the child's evolving capacities;
- work collaboratively with both children and their parents to involve them as fully as possible in treatment and other decisions that affect the child;
- provide children with the opportunity and time to reflect on the proposed options and make an informed decision;
- provide a comfortable and supportive environment to allow the child to exercise his or her capacities, and to ask questions as the process unfolds;
- work collaboratively with children and their parents to understand how decisions both affect or are affected by the child's unique circumstances (including their age, gender, culture, developmental capacities and abilities); and
- work with parents and children to ensure the child's best interests are intentionally considered and supported.

CASES FROM THE FIELD

Jill Kruger, University of Johannesburg

Children and teens often misunderstand the nature of their illness and treatment. This is difficult to correct for a number of reasons. Complex medical terminology is difficult for children to understand, and children often feel too shy or uncomfortable to ask questions of doctors or nurses. In the Phila Impilo programme* young patients used sock puppets to express their views during one-on-one conversations with health professionals. The socks gave children the confidence to ask questions and share their concerns, and enabled effective two-way communication about their illness and treatment options.

The puppet was my friend. It let me express what I felt but could not say (10-year-old boy).

* Chawla L & Kruger J (2008) Phila Impilo! Live Life! Ways to healing for children in long-term hospital care. *Participatory Learning and Action 58* (June): 128-133.

4.5 Children's right to protection and freedom and security of the person

Children are also entitled to protection from harm. Articles 19 and 37 of the UNCRC protect children from cruel, inhumane and degrading treatment and protect the child from all forms of violence, injury or abuse, neglect or negligent treatment, maltreatment or **exploitation**, including **sexual abuse.**

In the Constitution, these protection rights fall under the right to freedom and security of the person (section 12), as well as children's right to be protected from maltreatment, abuse, neglect and degradation (section 28(1)(d)). These rights have considerable similarities with articles 37 and 19 of the UNCRC. However the Constitution goes one step further and gives everyone a right to bodily and psychological integrity (also called the right to physical integrity) which includes the right to make decisions concerning reproduction; the right to security in and control over one's body; and the right not to be subjected to medical or scientific experiments without informed consent.

Consent plays a significant role in the realisation of children's right to physical and psychological integrity because the entitlement to consent allows a child to make decisions about their bodies and about their physical and psychological well-being. The right to physical and psychological integrity recognises patients as the ultimate decision makers when it comes to choosing what kind of treatment options to follow, and what they would allow to be done to their bodies in the course of receiving a health care service. These decisions are normally made in the form of consent, and the Children's Act provides clear guidance around the circumstances in which children are allowed to be the ultimate decision maker when it comes to receiving certain health care services. These consent provisions thus give effect to children's right to physical and psychological integrity.

Exploitation: To exploit children is to take advantage and treat them unfairly. Children can be exploited in different ways. Child pornography and child prostitution are examples of sexual exploitation. Child labour and using children to commit crimes are examples of economic exploitation.

Sexual abuse: In relation to a child, sexual abuse means: sexually molesting or assaulting a child, or allowing a child to be sexually molested or assaulted (subjecting the child to unwanted or improper sexual activity, for example, by touching or the child on his or her private parts); encouraging, inducing or forcing a child to be used for the sexual gratification of another person; using a child in, or deliberately exposing a child to, sexual activities or pornography; or giving a child, or anyone else, money or other rewards to for the child to perform sexual activities including prostitution and pornography; or allowing anyone else to sell the sexual services of children.

Health professionals also have a major role to play in the prevention of violence and in identification, diagnosis and referral. In addressing children's right to protection, health professionals must also have regard for the children's right to:

- express their views and have them taken seriously;
- respect for their evolving capacities;
- respect for their physical integrity[11]; and
- privacy and confidentiality.

Ensuring that these rights are all respected will involve consideration of the following:

- creating space for children to talk in confidence in line with their evolving capacities and to ensure privacy and confidentiality;
- applying the consent provisions in the Children's Act;
- being aware of and paying attention to signs that could suggest violence, abuse or neglect;
- where violence, abuse or neglect is suspected, asking the child about the situation in a manner that is respectful to the child and that respects his or her evolving capacities;
- exploring with the child your thoughts and concerns, your associated obligations (legal and ethical), and possible courses of action;
- if appropriate, discussing these factors with the child's parent/guardian;
- recording all cases of violence and suspected violence that you recognise;
- understanding and applying the current laws around protection and reporting violence, abuse and neglect;
- informing the child of your reporting obligations, before breaking confidentiality and getting the child's permission before sharing this information with parents or family members;
- developing and promoting policies regarding child protection and reporting of cases where violence, abuse and neglect are found or suspected;
- ensuring the child/adolescent is aware of these policies;
- educating children/adolescents about abuse and neglect, and encouraging and providing assistance for them to speak to someone they trust when they experience and/or witness violence, abuse and neglect;
- providing adolescents with information about healthy relationships; and
- when considering what is in the best interests of the child, taking account of the law, the views of the child, the implications of complying with or overriding his or her wishes, and the level of risk to the child.

[11] United Nations Committee on the Rights of the Child (2007) *Convention on the Rights of the Child. General Comment No. 8.* (arts 19; 28, para.2 and 37), (C/GC/8 March 2007) www.unhcrc.ch

4.6 The right to privacy and confidentiality

The UNCRC and the Constitution grant children the right to privacy, in respect of themselves as individuals, in their family and home, in institutions and in all forms of correspondence and communication. Respecting privacy is fundamental to respecting the dignity of the child.

It implies health care providers have both an obligation and an opportunity to:

- respect the child's body and his or her privacy, taking into account all contextual factors (culture, religion, gender, age, ability) and the consent provisions of the Children's Act;
- conduct consultations and treatments in an environment that respects the child's privacy and confidentiality;
- respect the confidentiality of children and adolescents to seek medical assistance and seek their consent before sharing private and/or confidential information with others (including parents and other health professionals);
- understand and apply the current laws around confidentiality and privacy;
- develop and promote explicit policies concerning access to confidential information, and ensure the child or adolescent is aware of these policies; and
- inform children when this confidentially needs to be breached (for example, when reporting abuse and neglect).

5. WHAT ARE THE GENERAL PRINCIPLES OF THE CHILDREN'S ACT?

The Act sets out general principles to guide the implementation of the Children's Act and all other laws that apply to children. The principles are based on children's rights in international law. In terms of these principles, all proceedings, actions and decisions to do with children must:

- respect, promote, protect and fulfil children's constitutional rights, the child's best interests, and the rights and principles set out in the Children's Act;
- respect the child's dignity and treat children fairly and equitably;
- protect the child from unfair discrimination – including discrimination based on the health status or disability of the child or his or her family;
- recognise the child's need for development – including the need for play and recreational activities that suit the child's age; and
- recognise a child with a disability and respond to his or her special needs.

The general principles also say that, in any matter concerning the child:

- the child's family should be given an opportunity to express their views (if that would be in the child's best interests);
- conflict should be avoided and people should work together to resolve their differences;
- people should try to avoid delays in taking actions or making decisions; and
- the child (depending on his or her age, maturity and stage of development) and the **person who has parental rights and responsibilities in respect of the child** must be informed of any actions or decisions that will affect the child significantly, and be made part of the decision-making process.

The general principles of the Children's Act guide all proceedings, actions and decisions concerning children regardless of which Act such action or decision falls under.

Person who has parental rights and responsibilities in respect of the child: The child's parent, guardian or caregiver is a person who has rights and responsibilities in respect of the child. It is important to note that generally caregivers do not have the full range of parental rights and responsibilities, and they must consult with a parent or guardian before making major decisions. Sometimes even certain parents do not enjoy full parental responsibilities and rights in respect of a child (e.g one parent could have a right of contact only while the other parent has guardianship over the child).

Chapter 2 of the Children's Act sets out the Act's governing general principles and provides guidance on the content and implementation of three of the UNCRC's general principles: the child's best interests, participation, and non-discrimination. In addition, it lists and gives guidance on a number of further general principles, including social, cultural and religious practices, information on health care, privacy and confidentiality, and the age of majority.

5.1 The best interests principle

Section 9 of the Children's Act says that *"the child's best interests [are] of paramount importance"* in all matters concerning the care, protection and well-being of a child. This means that the child's best interests must be considered and must be prioritised when any person makes decisions about any social service, care or other form of protection provided to the child and his or her family. However, there are certain circumstances in which other priorities may take precedence. Sachs advises:

> *[T]he fact that the best interests of the child are paramount does not mean that they are absolute. Like all rights in the Bill of Rights their operation has to take account of their relationship to other rights, which might require that their ambit be limited.*[12]

Who determines the best interest of the child? It is the responsibility of the health professional to determine and act in the best interests of the child.

[12] *S v M* (Centre for Child Law as Amicus Curiae) [2007] ZACC 18; 2008 (3) SA 232 (CC); 2007 (12) BCLR 1312 (CC) (S v M). Paras 18-9.

How do I know what a child's best interests are?

There is no easy answer to this question. Each case will be different, and professionals will have to make their own decisions. What the Children's Act does is to describe the factors that have to be taken into account when making a decision that is in the best interests of the child. Section 7 contains a long list of such factors. The following are the ones most relevant to health professionals:

- the child's age, maturity and stage of development;
- the child's gender;
- the child's physical and emotional security and his or her intellectual, emotional, social and cultural development;
- any disability or chronic illness that a child may have;
- the child's personal relationships with the parents, family or caregivers;
- the attitude of the parents, or any specific parent, towards the child;
- the capacity of the parents, or of any other caregiver, to provide for the needs of the child;
- the likely effect on the child of any change in the child's circumstances; and
- the need to protect the child from any physical or psychological harm, or witnessing harmful behaviour towards another person.

Please consult the Act for the full list.

Before making a determination, the health professional must make a holistic assessment of the child's physical, psychological and social well-being. Determining the child's best interests requires considering the child's views as this is the only way to predict the impact of a decision on the child's emotional well-being, to understand the child's concerns and fears, and ensure that he or she is fully aware of what is happening.

5.2 Children's participation

Following in the footsteps of international law, section 10 of the Children's Act states:

> *Every child that is of such an age, maturity and stage of development as to be able to participate in any matter concerning that child has the right to participate in an appropriate way and views expressed by the child must be given due consideration.*

Children's right to participate is one of the principles of the Children's Act, and it should be respected whenever a section of the Act (or any other Act) is being put into practice.

This means that the child's opinion should be heard and taken into account in all matters that affect him or her; similarly, children must be informed of any action or decision taken that will affect them in a significant way. It is important to remember that children's right to participate is not about taking decision-making away from adults, but ensuring that adult decisions are truly responsive to children's needs and protect their best interests.

In order to give effect to children's right to participation, it is important to think about the stage of development of individual children. Allowing children to communicate and express their views and wishes in a manner they are comfortable with is vital. Doing this means that you may have to be creative and make use of puppets, drawing or other forms of self-expression. Paying attention to children's body language, facial expressions and gestures is as important as listening to the words they say – particularly in the case of younger children.

How can we acknowledge and respect the views of infants and very young children?

Babies and neonates inability to speak should not be an obstacle to considering and respecting their point of view and feelings.

Non-verbal communication affords babies and neonates opportunities to express their feelings of anguish, fear, distrust, comfort and/or happiness through their actions. It is important that health professionals establish a positive relationship with the baby and his or her parents and involve/engage them during the consultation or treatment. This entails transmitting reassurance to the baby and caregiver, respecting his or her time and particularities (i.e. need for a nap or a feed), considering his or her pain, and avoiding or diminishing discomfort as much as possible.

Some children with disabilities may also experience difficulties in communicating verbally. It is equally important to explore approaches through which to listen to their views. Parents and caregivers will often be able to advise on how to understand and interpret their forms of communication.

It is important to note that all children are capable of expressing their views. Therefore it is necessary for health practitioners to explore the many ways that permit the child to articulate these views, concerns and opinions. The evolving capacities of the child must be taken into account.

5.3 Children with disabilities and chronic illnesses

The rights of children with disabilities are protected by international and regional laws.

The United Nations Convention on the Rights of the Child, especially article 23, recognises children with disabilities as a vulnerable group needing special protection to ensure they achieve the highest possible standard of health.

> *It is important to emphasize that health services should be provided within the same public health system that provides for children with no disabilities, free of charge, whenever possible, and as updated and modernized as possible. The importance of community-based assistance and rehabilitation strategies should be emphasized when providing health services for children with disabilities.*[13]

In the same vein, the United Nations Convention on Persons with Disabilities calls for full and effective steps to make children with disabilities a part of society. It also calls for such children to enjoy equal opportunities, respect, dignity, non-discrimination, and accessible services and programmes. This means that children with disabilities should have access to, and be included in, all services and programmes offered to children.

Section 11 of the Children's Act recognises the needs of children with disabilities and chronic illnesses and calls for special measures to ensure equal enjoyment of their rights. Section 11 is expressed as one of the general principles of the Act, which means that it should guide all proceedings, actions and decisions concerning children with disabilities or chronic illnesses.

Section 11 says that careful thought must be given to the form and manner of services and support provided in terms of the Act so as to ensure that:

- all children with disabilities and chronic illnesses are provided with parental, family or special care (as and when it is appropriate);
- conditions are created that ensure the dignity, self-reliance and active participation of children with disabilities or chronic illnesses in the community;
- support services are provided to these children and their caregivers; and
- opportunities are created for these children to share in social, cultural, religious and educational activities.

[13] United Nations Committee on the Rights of the Child (2006) *Convention on the Rights of the Child. General Comment No. 9. The rights of children with disabilities.* CRC/C/GC/9. 27 February 2007. Geneva: UNCRC.

Section 11 of the Act aims to ensure that children with disabilities or chronic illnesses are treated equally and with dignity, and that their right to participation is respected. It also aims to provide the children and their families with the necessary support services to prevent further discrimination or neglect. In addition, children with disabilities or chronic illnesses have the right not to be subjected to medical, social, cultural or religious practices that are harmful to their health, well-being or dignity.

The development of appropriate programmes and services to support children with disabilities is important to give effect to their rights. However, prevention is equally important. Giving parents, caregivers and communities useful information about how to prevent disability is a major step towards protecting children's health and well-being.

CASES FROM THE FIELD

Jane Booth (Red Cross War Memorial Children's Hospital)

On the Breatheasy Programme at the Children's Hospital we use teddy bears and real tracheostomy tubes, scissors and suction machines for children to practice the procedures that their parents have been responsible for as soon as the child starts to assert some form of independence. This is usually around the time of potty training. Children love learning through play, this releases anxiety and gives them important self-help skills.

A tracheostomy is complex medical procedure done to relieve airway obstruction or to assist with breathing (ventilation). Although this remains a high-risk procedure, medical technology has advanced to such an extent that we are now able to offer family-based care to our patients, improving their quality of life. Parents need to have the knowledge, skills and equipment in order to take their children home.

One of the vital parts of home care training is to consider the inclusion of the children with chronic illness in their own care. Children with chronic illness, more than other kids, need chances to make choices and to have control over areas of their lives that within reason they can control.

Including the children helps them to understand their condition and helps staff and parents to work together to create a sense of independence and mastery for the children. Participation and assertion of their own ideas will then come naturally in later life.

5.4 Social, cultural and religious practices

Section 12 protects all children against social, cultural and religious practices that are detrimental to their well-being. Certain practices are banned (female genital mutilation and forced marriages) while others are limited to children over the age of 16 and regulated to prevent abuse (virginity testing and male circumcision for cultural reasons).

Genital mutilation or circumcision of girls

Section 12(3) prohibits genital mutilation or circumcision of girl children. Anyone who contravenes the prohibition is guilty of an offence and can be fined or imprisoned for 10 years or be given both a fine and a term of imprisonment (section 305(1)(a) and (6)).

Virginity testing

Section 12(4) prohibits virginity testing of children under the age of 16 years. Anyone who contravenes the prohibition is guilty of an offence and can be fined or imprisoned for 10 years or be given both a fine and a term of imprisonment (section 305(1)(a) and (6)).

Virginity testing of children older than 16 may be performed but only under strict conditions that are specified in the Act and the Regulations:

- the child must consent to the test – i.e. it must be the child's choice (the child must sign **Form 1**);
- the test may only be performed after the child has been counselled properly;
- the child's age must be verified;
- each child should be tested individually and in private;
- the test must be done in a hygienic manner (in particular, a separate pair of sterile surgical gloves must be used for each child);
- only a female can test a girl child and only a male can test a boy child;
- the results of the test may not be disclosed without the child's consent; and
- after the test, the child's body may not be marked in anyway (i.e. the outcome of the test must be kept confidential).

It is an offence not to comply with these requirements and a person is liable on conviction to a fine or to imprisonment for up to two years in some cases, or even up to 10 years in other cases, or to both a fine and imprisonment.

Form 1: Consent to a virginity test by a child.

CASES FROM THE FIELD

Dr Neil McKerrow (Department of Health, KwaZulu-Natal)

Thirteen-year-old Candice arrived at the paediatric outpatient clinic one Monday morning accompanied by her mother. Her mother demanded that the doctor assess Candice's virginity to determine whether or not her daughter was sexually active. Candice's mother believed that her daughter was physically mature for her age, that she was socialising with older children who she felt were a bad example and that these older children were exploiting Candice.

The previous Friday evening Candice had gone out with her new friends and only returned home late on the Saturday morning. Despite Candice's repeated denials to the contrary, her mother was adamant that Candice had spent the night out so that she could have sex and wanted a physical examination of her daughter in order to confirm her suspicions.

Although she has come to the hospital with her mother, Candice claims that her mother doesn't trust her, is being unreasonable and has gone crazy. She states that she does not agree to the examination and has no intention to undress or cooperate with the doctors or nurses if they try to examine her.

Section 12(4) of the Children's Act states that virginity testing of children below the age of 16 is prohibited. There is no distinction between cultural and medical testing and in this instance a virginity test cannot be performed.

Where there is evidence of sexual abuse, a medical professional can perform an examination even in the face of refusal from the child. In this case it is not clear if there was any sexual activity and if so it may well have been consensual and would therefore not be considered a criminal offence. In this instance one needs to consider the reasonableness of both Candice and her mother's behaviour. Both parties require counselling and support but unless Candice consents to an examination this should not be performed.

Circumcision of boys

Medical circumcision is considered to be a surgical operation and can be performed at any age on the recommendation of a medical professional subject to the consent provision in section 129. Religious circumcision can also be performed at any age so long as the parents consent; and the person performing the circumcision is properly trained and follows the procedure outlined in Regulation 6 (see below). Social or cultural circumcision of male children under 16

years is prohibited. Anyone who contravenes the prohibition is guilty of an offence and can be fined or imprisoned for 10 years or be given both a fine and a term of imprisonment (section 305(1)(a) and (6)). The Act and Regulations set out the general requirements for conducting circumcisions on boy children:

- A boy child has the right to refuse circumcision (taking into consideration his age, maturity and stage of development).
- The circumcision can only be done by a medical professional or a person who has knowledge of the social or cultural practice or religious practice and who has been properly trained to perform circumcisions.
- The person performing the circumcision must:
    - use sterile surgical gloves and dispose the gloves after each circumcision;
    - dispose or sterilise instruments used after each circumcision;
    - dispose instruments or human tissue in accordance with medical standards; and
    - ensure that there is no direct contact with blood or bodily fluid or foreign substance of the child, the practitioner or any other person.

For boy children 16 years and older, the following requirements must also be met:

- the boy must first consent to the circumcision – i.e. it must be the child's choice;
- the boy's parent or legal guardian must assist the child;
- the boy must receive proper counselling; and
- the boy's age must be verified.

5.5 Information about health, health status and treatment

Section 13 of the Act recognises and protects children's right to information about their health. This includes general information about leading a healthy lifestyle and preventing ill-health and disease. It also includes information about sexuality, reproduction and contraception.

In addition, children have a right to know about any illnesses they may have, such as HIV, and to receive information about the causes of their illness and the various options for treatment and care. The right to health information is an essential prerequisite for children's participation in decisions about what happens to their bodies.

Health professionals have a responsibility to make sure this information is presented in such a way that children at different stages of development, including children with disabilities, can understand it. See page 21 above.

5.6 Privacy and confidentiality

Privacy and respect for confidentiality are issues that are especially important for older children. The right to privacy is enshrined in South Africa's Constitution as well as African and international law. In keeping with this, the Children's Act describes specific situations in which the right must be protected (for example, in the case of health matters and certain court proceedings). Section 13 of the Act protects children's right to confidentiality about their health status and that of their parents and caregivers. It is a criminal offence to tell other people about the HIV status of a child without the proper consent.

It must be pointed out, however, that the Act has nothing to say about privacy and confidentiality in the more day-to-day affairs of children. The UNCRC provides clearer guidance in this respect.

Other examples of where it is important to consider children's privacy in health care practice include:

- closing the curtains when conducting a physical examination;
- asking before lifting up a child's shirt;
- ensuring patient files and records are stored confidentially; and
- considering how best to respect the confidentiality of children and families during ward rounds especially when discussing HIV and social problems.

5.7 Age of majority

According to the Children's Act, children reach the age of majority (that is, become adults) when they turn 18. Generally, children need their parents' consent to take big decisions, but once they reach the age of 18 they are considered legally responsible for their own actions or omissions.

6. WHAT ARE THE CONSENT PROVISIONS IN THE CHILDREN'S ACT?

6.1 When does a child have the capacity to consent?

The old Child Care Act set the age of consent for medical treatment (which at that time included HIV testing and contraceptives) at 14 years. A child could only consent to surgery on their own if they were 18. The Children's Act lowers the age requirement of consent for these services to 12 years and introduces the additional requirement of a maturity assessment to determine the child's capacity to consent.

The table in Appendix A summarises the provisions that govern children's consent to medical treatment, surgical operations, HIV testing, disclosing their HIV positive status and accessing contraceptives.

a) Consent to medical treatment and surgical operations

Section 129 of the Children's Act states that a child may consent to his or her own medical treatment or to the medical treatment of his or her child if:

(a) the child is over the age of 12 years; and

(b) the child is of sufficient maturity and has the **mental capacity to understand the benefits, risks, social and other implications of the treatment.**

A child may consent to the performance of a surgical operation on him or her, or on his or her child if:

(a) the child is over the age of 12 years; and

(b) the child is of sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications of the surgical operation; and

(c) the child is duly **assisted by his or her parent or guardian.**

As in previous legislation, there is no definition of "medical treatment" or "surgical operation" in the Act. Treatment would refer to non-invasive and innocuous procedures, and include vaccinations and psychological treatment. A "surgical operation" generally refers to invasive surgical interventions.

Do you need consent for an examination?

The Children's Act specifies that a child must consent to an examination for the purposes of establishing if the child has been abused or neglected, and the criminal law states that the parent must also consent to such an examination. The Act says nothing about the child or parent's right to consent to a general medical examination; however, the Act authorises caregivers to consent to an examination where a parent or guardian is not available[14]. This omission does not mean that examinations can be performed without consent from the child or the parents:

> *To treat competent patients without their valid consent is a violation of their constitutional rights and transgresses a fundamental principle of medical law. The basic rule is simple: no-one has the right to* ***touch*** *anyone else without lawful justification and if doctors do so it may well undermine patients' trust as well as violate their rights to physical integrity.* [15]

What does it mean to be assisted by a parent or a guardian?

In the case of surgery, children over 12 who have sufficient maturity need to be assisted by the parents to reach a decision. If the parent refuses to assist the child and to sign the assent form, then the surgery cannot be performed unless ministerial or court-ordered consent is obtained to overrule the parent's refusal to assist.

According to Regulation 48, the child consenting to his or her own surgery and the parent or guardian who assists the child must do so in writing on **Form 34.** This form must be completed by the person performing the operation or a representative of the institution at which such operation will be performed and signed by the child and the parent.

When completing the form, the health professional performing the operation (or the representative of the institution) is required to indicate that he or she has explained to the child the nature, consequences, risks and benefits of the surgery, and that he or she is satisfied that the child is of sufficient maturity and has the mental capacity to understand the risks, benefits, social and other implications of the operation.

Form 34: Consent to surgical operation by a child

[14] Section 32.
[15] Medical Protection Society (2010) *Consent to Medical Treatment in South Africa - An MPS Guide.* 2nd ed. Medical Protection Society.

When it comes to surgery for a child whose parent is under 18 years of age (i.e. a child parent) the Act and Regulations require the child parent to be assisted by his or her parent or guardian (i.e. the grandparent of the child to be operated on). The child parent must consent and the grandparent must assent to the operation in writing on **Form 35.**

b) HIV testing

A child may be tested for HIV if testing is in the best interests of the child and consent is given by the child or the child's parent or caregiver. According to the Department of Health's HIV Counselling and Testing (HCT) Policy Guidelines:

> *an HIV test will be in the best interests of the neonate, infant or child if it is clear that the test will provide access to the continuum of care and promote a child's physical and emotional welfare.* [16]

The Act sets out the following rules regarding the child's capacity to consent to an HIV test:

- if the child is over 12 years, then the child can give consent without his or her parent's knowledge; and
- if the child is under 12 years and sufficiently mature enough to understand the benefits, risks and social implications of the test, then the child can consent him- or herself.
- if the child is under 12 and is not mature enough, then the parent or caregiver must give consent on the child's behalf.

The department's guidelines on HCT say:

> *A child is considered to be sufficiently mature if they can demonstrate that they understand information on HIV testing and can act in accordance with that appreciation. In deciding whether a child is sufficiently mature factors that should be taken into account include:*
>
> *Age: the older the child the more likely it is that they will have sufficient maturity;*

Form 35: Consent to surgical operation of a child by a parent

[16] Department of Health (2010) *HIV Counselling and Testing (HCT) Policy Guidelines, March 2010.* Pretoria: DoH, p31.

Knowledge: children with knowledge of HIV and its implications are more likely to understand its consequences;

Views: children who are able to articulate their views on HIV testing and whether it is in their best interests are likely to meet the maturity requirements; and

Personal circumstances: an assessment of the child's personal situation and their motivations for HIV testing may help in assessing their maturity.[17]

Pre- and post-testing counselling for HIV

Pre-and post-testing counselling must be provided to the child. The Act states that testing may only be done after proper counselling by an appropriately trained person. The HCT policy guidelines stipulate that *"where children are counselled and tested, staff should have appropriate understanding or specific training in child development, communication with children, and appropriate counselling guidelines".*[18]

The parent or caregiver must also be counselled if they have knowledge of the test or have consented on the child's behalf. The Department of Health has indicated that this obligation to do pre- and post-test counselling requires HIV-testing facilities that test children to:

Be staffed with persons who should be able (through experience and/or training) to assess the developmental capacity of children to ensure that they are of sufficient maturity to understand the benefits, risks and social implications of such a test in terms of the Children's Act no. 38 of 2005 as amended (S132 (1) (a).

Ensure that both pre- and post-test counselling is offered in every instance.

Establish the child's maturity to understand the benefits, risks and social implications of the counselling before offering the child pre- or post-test counselling.

Counsel children who are mature enough to understand the implications of the HIV test.

[17] See note 16 pp. 32-33.
[18] See note 16 p. 73.

Inform children who are not mature enough to understand the implications of the HIV test that their parents or care-givers need to be involved in the counselling process to assist them.

Advise children with the maturity to undergo counselling on their own that they may voluntarily involve their parents or care-givers in the counselling process.[19]

c) Disclosure of HIV/AIDS status

Children's right to choose whether or not to disclose their HIV status is rooted in their constitutional rights to privacy and physical integrity. Thus the State and its agents (like health professionals) are not allowed to unduly interfere in a child's right to choose whether or not to disclose. However the child's right to freedom of choice is not absolute and it can be limited, but the limitation must be reasonable and justifiable. For example, a health professional may override a child's refusal if they have evidence that there is a risk to a third party if they do not disclose i.e. the child is having unprotected sex with another child.

Section 133 provides that information on a child's HIV status must be kept confidential, but there are some exceptions: for the purposes of legal proceedings, if there is an imminent threat of harm to a third party, or *"when necessary for the purposes of carrying out the provisions of the this Act".* Arguably this would include getting consent for treatment (see below).

Breaching confidentiality without the appropriate consent is an offence with a penalty of a fine or imprisonment for up to 10 years. This could create problems where a child under 12 years gives consent for an HIV test and the results are positive. A child under 12 cannot consent to treatment, but can refuse to disclose the results to the parent or guardian. In this case, the health professional should encourage the child to disclose to the parent, guardian or caregiver.

If all attempts to persuade the child to disclose his/her status to the parents or caregiver fail, the health professional has two options: either approach a court if the child is unreasonably withholding consent and disclosure is in the best interest of the child; or approach the superintendent of the hospital who can consent to treatment if the need for the treatment is so urgent that it cannot be deferred for the purpose of obtaining consent. There is no case law or definitive ruling on such a case and doctors are advised to approach such matters with extreme caution.

[19] See note 16 p. 32.

d) Contraception

The National Contraception and Fertility Planning Policy Guidelines[20] (issued by the Department of Health) regard preventing pregnancy and sexually-transmitted infections (STIs) as a critical part of child protection. In accordance with this policy, the Children's Act facilitates children's access to contraceptives. The objective is to prevent sexually-active children from contracting STIs (including HIV) or falling pregnant.

Section 134 of the Act states that no person may refuse to sell condoms to a child over the age of 12 years; or to provide a child over the age of 12 years with condoms on request where such condoms are provided or distributed free of charge. A person who disregards these provisions is guilty of an offence and can be fined or imprisoned for 10 years or be given both a fine and a term of imprisonment.

Contraceptives other than condoms may be provided to a child on request from the child and without the consent of the parent or caregiver of the child if:

- the child is at least 12 years of age; **and**
- proper medical advice is given to the child; **and**
- a medical examination is carried out on the child to determine whether there are any medical reasons why a specific contraceptive should not be provided to the child.

Finally, a child who obtains condoms, contraceptives or contraceptive advice in terms of this Act is entitled to confidentiality. However, this is subject to section 110(1) of the Act which obliges health professionals to report cases of physical or sexual abuse, or deliberate neglect of a child to the Department of Social Development, a **designated child protection organisation** or the police (see section 7).

Designated child protection organisation: A child protection organisation that has been given written approval by the Director-General or provincial Head of Social Development to perform child protection services.

[20] National Department of Health (2012) *National Contraception and Fertility Planning Policy and Service Delivery Guidelines: A Companion to the National Contraception Clinical Guidelines.* Pretoria: DoH

e) Termination of pregnancy

It is important to know that consent by a child to a termination of her pregnancy (TOP) is not regulated by the Children's Act but by the Choice on Termination of Pregnancy Act 92 of 1996 (CTOP). Therefore, even though a TOP is a "medical treatment" or "surgical operation" (depending on the stage of the pregnancy), section 129 of the Children's Act does not apply.[21]

Section 5 (read with the definition of a "woman" in section 1) of the CTOP Act provides that a woman of any age can consent to a termination of her pregnancy and only her consent is required. This effectively means that there is no age threshold specified in the law in relation to children's legal capacity to consent to TOPs.

However, because *"[c]apacity to consent depends on the ability to form an intelligent will on the basis of an appreciation of the nature and consequences of the act consented to"*[22] the child needs to be able to give valid consent before a TOP can be performed. Health professionals will need to individually assess each child's ability to give valid consent and make a judgment call on each case. The best interests of the child principle should guide this judgement call.

Note also that the reporting obligations in the Children's Act also apply to TOPs – see section 7 below.

6.2 How do we assess children's capacity to consent?

A child's capacities are highly dependent on the child's life experiences. For example, young children who have experienced major surgery or frequent medical interventions may have a profound understanding of life or death and how decisions will affect them. While a 5-year-old child may lack the competence to decide which is the best hospital for an operation, he or she can indicate if and why he or she feels comfortable at the hospital, and provide suggestions to improve his or her stay.

When children are given appropriate support, adequate information and opportunities to express themselves meaningfully (through pictures, poems, drama, photographs, as well as more conventional discussions, interviews and group work), all children can participate in clarifying and resolving issues that are important to them.[23]

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[21] Section 129(1) of the Children's Act 38 of 2005 expressly excludes TOPs from the ambit of the Children's Act.

[22] Judge Mojapelo in *Christian Lawyers Association v Minister of Health and others (Reproductive Health Alliance as Amicus Curiae)* 2005 (1) SA 509 (T). pp 515-516.

[23] See for example Kruger J & Coetzee M (2011) Children's relationships with professionals. In: Jamieson L, Bray R, Viviers A, Lake L, Pendlebury S & Smith C (eds) *South African Child Gauge 2010/2011.* Cape Town: Children's Institute, University of Cape Town.

Health professionals need to listen to children, provide appropriate information and give them time to articulate their concerns, so that children can develop the confidence and ability to contribute effectively to their own health care. These are critical prerequisites/foundations for informed consent, but how exactly are health professionals supposed to assess children's capacity to consent?

Deciding on whether a child is mature enough to give consent requires that the child has full knowledge of the procedure, and understands the nature of the risk of the treatment or surgery (including the social or other consequences of the treatment or surgery). Different types of treatment require different levels of understanding and responsibility. For example, a 12-year-old child may be mature enough to understand the risks and benefits of receiving a cast for a fractured arm, but the same child may not be mature enough to understand the risks and benefits of undertaking long-term treatment for a chronic illness such as tuberculosis.

In the case of medical treatment where the health professional concludes that a 12-year or older child is not mature enough to give consent, the health professional must seek consent from the parent, guardian or caregiver. In the case of surgery where the health professional concludes that a 12-year or older child is not mature enough to give consent, the health professional must seek consent from the parent or guardian.

Benefits and challenges in implementing the consent requirements

While lowering the age requirement allows more children to be able to access health care services on their own, it also puts more strain on health providers to determine whether this larger number of children have the capacity to consent to the relevant health services on their own.

Determining maturity can be challenging, and time consuming. In addition, there are no guidelines from the Act or its Regulations on how to assess maturity or mental capacity and this could lead to children in similar situations being treated differently.

Despite these challenges there are significant benefits for children.

- Children are treated as individuals with different needs and capacities.
- Allowing younger children to consent increases access to health care services.
- Applying the maturity test ensures that older children who lack decision-making capacity are not burdened with responsibilities with which they cannot cope.
- The new model encourages children to take more responsibility for their own health care and improves adherence to treatment.

Who must assess if the child has sufficient maturity and mental capacity?

Currently, some health facilities allow receptionists and administrators to complete the consent forms. However, explaining the nature of the operation and assessing the maturity of a child and whether the child has the mental capacity to understand the risks, benefits, social and other implications of the operation is a task that should only be done by people with the necessary skills and training.

6.3 What happens when the child lacks the capacity to consent?

Where a child is too young or lacks the capacity to consent, the Children's Act gives the decision-making power to others (for example the parent or caregiver) in order to protect the child from the burden of making difficult decisions. However, children who lack capacity still have the right to participate and have their views considered.

The Children's Act and the National Health Act respect the rights of *all* child patients to participate in decisions affecting their health and well-being and to have their views and opinions considered and respected. However, this right to participate doesn't always extend to a right to make decisions. The prescribed age and maturity requirements draw a line between children who are entitled to participate, and those who can also make the ultimate decision (give or refuse consent).

a) Who can consent to medical treatment?

The Act provides clear guidance on who else is authorised to consent when the child lacks the capacity to consent. When the child cannot consent to medical treatment, the parent, guardian or caregiver is authorised to give the necessary consent.

Where the parents of the child receiving treatment are under 18 years old, the parents must be subject to the same maturity test as they would for their own treatment. If the child parent does not pass this test, then the parent, guardian or caregiver of the child parent must consent to the treatment of the younger child.

b) Who consents to surgery?

The same conditions apply as for medical treatment, except that caregivers cannot consent for surgery.

c) Who consents to HIV testing?

If the child is under 12 and not mature enough to consent to an HIV test then the following people can consent on behalf of the child:

- the parent or caregiver;
- the provincial head of social development;
- a designated child protection organisation (DCPO) arranging the placement of the child;
- the superintendent or person in charge of a hospital (if there is no parent or caregiver and no DCPO arranging for the child's placement); or
- the children's court (if consent is being withheld or the child, parent or caregiver is incapable of consenting).

A child may also be tested in the following circumstances:

- if during the course of a medical procedure, a health worker has had contact with any substance from the child's body that may transmit HIV, and there is a suspicion that the health worker may have contracted HIV due to contact; or
- if any other person may have contracted HIV due to contact with any substance from the child's body that may transmit HIV, provided the test has been authorised by a court (for example if the child is accused of sexually assaulting another person and a compulsory HIV test under the Sexual Offences Act has been authorised by the court).

In certain circumstances the State is required to pay for a child's HIV test, for example, if the test is done for the purpose of placing the child in foster care or adoption (section 131).

d) Who consents to the disclosure of the child's HIV positive status?

The same conditions apply as for HIV testing – except that the provincial head of social development cannot consent to the disclosure of HIV-positive status.

6.4 When can parents, guardians caregivers, foster parents and heads of child-headed households give consent?

If a child does not have the capacity to consent because he or she is too young; lacks the maturity and mental capacity to understand the risks and benefits of the treatment surgery or test; or is unconscious; then certain people can consent on the child's behalf. What they can consent to depends on their relationship to the child and the nature of the health service required.

Parents

When both parents have full parental rights, either parent may consent individually to medical treatment or surgery. However, where a decision could *"significantly change, or have an adverse effect on the child's … health"* the person giving consent must take into consideration *"any views and wishes expressed by any co-holder of parental responsibilities and rights"*[24], e.g. the other parent.

Adoptive parents have full parental responsibilities and rights.

Biological mothers: The biological mother of a child, whether married or unmarried, has full parental responsibilities and rights. However, if the biological mother is under 18 years, the guardian of the biological mother is also the guardian of the child (s19). Notwithstanding this section, a child may consent independently to the medical treatment of her child. However, in cases of an operation on such child, the under-18-year-old mother must be assisted by her own parent or guardian.

Biological fathers: The biological father of a child has full parental responsibilities and rights in respect of the child if he is married to the mother of the child or was married to the child's mother at the time of the child's conception, birth or anytime between conception and birth. However in the case of a divorced father (and mother) the court order will indicate which rules apply with respect to guardianship, care (new term for "custody") and contact (new term for "access") when it comes to the child.

For unmarried fathers the situation is slightly different. Under the old law, an unmarried father had no parental rights and responsibilities and he had to approach the High Court to be assigned parental rights and responsibilities. The Children's Act has now changed the law so that an unmarried father who is committed to caring for his children can have equal parental rights and responsibilities without having to approach the High Court.

Section 21 of the Act provides that the father acquires full parental responsibilities and rights under two distinct sets of circumstances:

He has full parental rights and responsibilities if he is living with the child's mother at the time of the child's birth in a permanent life-partnership.

[24] Section 31.

Regardless of whether he has or has not lived with the mother, he can also acquire rights if the following three conditions are present:

- he consents to be identified as the father or applies to the court to be recognised as the child's father or pays damages in terms of customary law;
- he contributes or has attempted to contribute in good faith to the child's upbringing for a reasonable period; and
- he contributes or has attempted to contribute in good faith to the expenses in connection with the maintenance of the child for a reasonable period.

If there is a dispute as to whether any of these conditions exist then the matter must be referred for mediation to a family advocate, social worker, or social service professional. In cases where the unmarried father does not acquire rights and responsibilities in terms of section 21, he can acquire such rights by entering into an agreement with the mother. The agreement must be registered with the family advocate and it must be made an order of the High Court.

Caregivers

A caregiver is anyone who cares for the child including grannies, aunts, foster parents, temporary safe carers, the head of a child and youth care centre, a child and youth care worker mentoring a family, or a child heading a household.

Heads of child-headed households

The Act recognises the child heading the household as the caregiver of the younger children. He or she has all the rights and responsibilities of a caregiver, for example, the right and responsibility to consent to the medical treatment or HIV-testing and disclosure of the younger children.

Section 137 of the Act allows for the legal recognition of child-headed households by the provincial Head of Social Development if:

- the parent, guardian or caregiver of the household is terminally ill, has died or has abandoned the children;
- no adult family member is available to provide care;
- a child over the age of 16 years is willing to assume the role of caregiver; and
- it is in the best interest of all the children in the household.

Before a household can be recognised as a child-headed household, a **designated social worker** must complete an investigation to determine that the children are not in need of care and protection and do a developmental assessment of the child heading the household to determine if he or she has the capacity to become the head of the household.[25]

Foster parents

Foster parents are caregivers and usually they cannot consent to surgical operations. However, if the child has been **abandoned** or orphaned, the children's court can confer parental responsibilities and rights – including the power to consent – on the foster parent. This would be part of the court order.

Before making any major decisions involving the child, the foster parent must consider the views and wishes of the child depending on the age, maturity and stage of development of the child, and any views and wishes expressed by the child's guardian or parent. The foster parent is only required to give due consideration to these views and wishes – he or she does not have to follow them. Although the foster parent does not need the consent of the child, parent or guardian before making a major decision, he or she must think about their views very seriously.[26]

Major decisions include:

- decisions that would affect contact between the child and his or her parents; or
- decisions likely to change, or have a negative effect on, the child's living conditions, education, health, personal relation with a parent or family member or, generally, the child's well-being.

Designated social worker: A designated social worker is any social worker who works for the Department of Social Development, a municipality or a designated child protection organisation. There are many times when the Children's Act says that a certain task should be done only by a designated social worker.

Abandoned: A child is abandoned if he or she has been deserted by their parent, guardian or caregiver, or if he or she has not had contact with their parent, guardian or caregiver for at least three months for no apparent reason.

[25] Department of Social Development (2010) *Norms, Standards and Practice Guidelines for the Children's Act*, May 2010. Pretoria: Department of Social Development, p 247.
[26] Section 188(2) read with section 31.

6.5 What happens if there is no parent, guardian or caregiver to give consent?

If the parent, guardian or caregiver cannot consent or they cannot be traced or they are deceased then the Minister of Social Development can give consent, this should be done on a **Form 33**, but the process can take time.

If all those authorised to consent (the child, parent, guardian, caregiver) are unable to consent, then the High Court or children's court can be approached for consent, this process can happen quickly if an urgent application is made.

In the case of HIV testing and disclosure the designated child protection organisation arranging the placement of a child in alternative care or the adoption of the child can consent.

CASES FROM THE FIELD

Dr Lucy Linley, Mowbray Maternity Hospital

Chad was born 10 weeks premature. He was admitted to the neonatal unit immediately after birth. His mother, Zoe, visited him when he was nine hours old. She was 24 years old, had not attended antenatal clinic, and appeared very anxious and distracted. It soon emerged that Zoe was desperate to go home that same day.

When she was questioned, she admitted to having "tried tik once or twice". Later the same day, Zoe absconded, leaving her little boy in the neonatal unit.

Zoe never returned to see her baby. She answered calls from the hospital on three occasions, then became uncontactable. Her family was contacted, came to see the social worker, and revealed that Zoe was living with her boyfriend at an unknown address, and that both were drug addicts.

At seven weeks of age, Chad was diagnosed with an inguinal hernia. He needed surgery under general anaesthetic. According to the Children's Act, the neonatal team needed to get consent for the operation from Chad's mother. When this proved impossible, his grandmother offered to give consent. The grandmother could not give consent as she is not the legal guardian. Neither could the medical superintendent as this is not a life-threatening emergency. So the hospital decided to approach the court to get a speedy decision. Baby Chad recovered well from surgery, and was being prepared for discharge when it became apparent that Zoe's family was not able to care for him. Chad was effectively abandoned so the hospital reported the matter to social services. Chad was placed in foster care, and he was adopted when he was five months old.

Form 33: Application for consent to medical treatment or surgical operation by the Minister.

6.6 What happens when a child refuses to give consent?

a) If a child has the capacity to consent.

Children who meet the necessary age and maturity requirements are required to give consent to treatment, surgery, HIV testing and the disclosure of their HIV-positive status. This means that children cannot be subjected to these procedures against their will.

A child who has the capacity to consent is also entitled to refuse treatment or surgery.

If a child unreasonably refuses to give consent, then the Minister of Social Development or the courts (not the parent, caregiver or guardian) must be approached to overrule the child's refusal. The court can also issue a treatment order for the child (section 156(1)(i)).

b) If the child does not have the capacity to consent.

If a child 12 or older is mentally ill and the health professional assesses them not to have the mental capacity to consent or refuse treatment (due to their mental illness) then their parents, guardian or caregiver must make the decision on their behalf. (See the Mental Health Care Act for additional requirements for involuntary admissions into mental health care facilities.)

Nothing prevents the child from asserting his or her autonomy and exercising his or her constitutional rights to physical integrity (the right to make decisions about one's body). This can be done by a child (or his or her representative) approaching a court to prevent a parent, guardian or caregiver or anyone else from subjecting him/her to medical procedures.

However, a health provider who acts on the instruction (consent) of a parent is acting within the law, even if the child (who lacks capacity to consent) is against the decision.

6.7 What happens when parents, guardians or caregivers refuse to give consent?

If the child lacks capacity to consent, then the parent, caregiver or guardian must consent on their behalf. Such a parent, caregiver or guardian can also refuse to give consent.

However medical treatment and surgery cannot be refused solely based on religious or other beliefs. There must also be a medically-accepted alternative to the proposed treatment or surgery.

If a parent, caregiver or guardian unreasonably refuses to give consent to treatment, surgery, HIV testing or the disclosure of a child's HIV-positive status, then the Minister of Social Development or the courts can be approached to overrule their refusal and to consent on the child's behalf.

CASES FROM THE FIELD

Dr Rowan Dunkley (Red Cross War Memorial Hospital)

Vuyo was six weeks old. His twin brother had recently passed away in hospital following sepsis secondary to Group B Haemolytic Streptococci. Amy his mother was HIV positive, and had been informed that she could have been the carrier of the infection acquired at the time of delivery. Vuyo's parents were advised to bring him in for a check-up which they duly did. Vuyo was well and investigations revealed no evidence of infection and he was discharged on oral antibiotics. Ten days later Vuyo became unwell with fever, vomiting and diarrhoea. This time the tests suggested he may have meningitis and his parents were informed that it could be caused by the same infection. Vuyo was admitted to hospital for treatment with HIV antibiotics.

Three days later some tests results came back suggesting that the infection was caused by a different organism. The antibiotics were adjusted and his mother was informed. At this stage Vuyo's parents were becoming very dissatisfied with their treatment. It was noted that two doses of antibiotic had been missed or not signed for, and concern was raised that a dose of Nevirapine had been delayed significantly. The parents were unhappy with the quality of care and wanted to take Vuyo home immediately.

After extended counselling the parents still said they wanted to leave immediately. The doctor on duty explained that they could not take him home as this would, in the doctor's opinion, place the life of their child in jeopardy. He explained that arrangements for transfer and a second opinion could be made in the morning if they wished, but if they insisted on leaving then he would contact the social worker and try to arrange for legal protection of the child. Although the parents were extremely angry at this overriding of their parental rights, they eventually agreed to not leave the hospital. Following further discussion with the parents the following day they remained at the hospital and completed treatment.

The conflict here probably arose from the initial carers not adequately explaining and involving the parents in the management decisions about their child. It is likely that the grief from their recent loss at the same institution made it more difficult for the parents to cope and to understand and engage with the medical staff, as support for the parents to deal with this had been inadequate. Although rightfully wishing to exercise their parental duty of care by seeking alternate care, leaving the hospital without a clear plan for on-going care was not in the best interests of the child.

6.8 What happens when one parent consents and the other parent refuses to consent?

If both parents have parental rights and responsibilities in respect of the child, then only one of them need to consent unless a court order says otherwise (i.e. if a divorce order states that both parents must consent). For example, if the mother consents and the father refuses, then the medical team should try and support the family to reach consensus. Where there is not time for such mediation or it fails, the team may proceed with treatment. However the consenting parent has to take into account the views of the parent who refuses to consent, but does not have to act in accordance with those views. If the non-consenting parent wants to prevent the treatment or surgery from taking place, he or she will have to get a court order to that effect.

6.9 When is it "unreasonable" to withhold consent?

"Unreasonableness" would differ from case to case. An example would be where the parents of a severely burned child refuse to take him for medical treatment because they want to treat him with herbal remedies. Or where the parents of a child suffering from leukaemia refuse chemotherapy because of concerns that it would damage her immune system and cause other long-term problems, and they want to rather use alternative approaches including nutritional supplements, changing her diet and reducing her stress levels.

6.10 What happens when a parent withholds consent on religious or cultural grounds?

No parent, guardian or caregiver of a child may refuse to assist a child or withhold consent by reason only of religious, cultural or other beliefs. They must be able to show that there is a medically-accepted alternative to the medical treatment or surgical operation concerned (section 129(10)).

The Jehovah's Witnesses have a worldwide network of more than 1,700 Hospital Liaison Committees (HLC). This network provides information regarding clinical strategies to avoid blood transfusion and facilitates access to health care for patients who are Jehovah's Witnesses. To contact a South African HLC representative, phone 011 761 1000 or 083 226 5959.

CASES FROM THE FIELD

Prof Andrew Argent (Red Cross War Memorial Children's Hospital)

A three-year-old girl was admitted to the paediatric intensive care unit (PICU) with haemolytic anaemia and severe cardiac failure. Her haemoglobin had dropped to 3g/dl and she was profoundly shocked. Both parents were Jehovah's Witnesses and refused to provide consent for administration of blood products.

An emergency meeting with the parents, a representative of the Jehovah's Witness church and the medical director of the PICU was constituted. At that meeting the medical director explained the nature of the problem and the reason why blood products were essential to save her life (and why no alternative products or procedures were possible). The parents stated that they were unable to give consent for the procedure. The medical director explained that unfortunately in that situation he had no alternative but to obtain consent through the hospital superintendent as in his opinion failure to administer blood products would severely compromise the best interests of the child.

The family accepted that position, the medical superintendent provided signed consent for administration of blood products and blood was given to the child.

CASES FROM THE FIELD

Dr Neil McKerrow (Department of Health, KwaZulu-Natal)

Nomusa, a three-year-old girl with arrested hydrocephalus, was brought to hospital by her mother who was concerned that she had become increasingly drowsy over the preceding few days. Until then, despite her large head, Nomusa had essentially been a normal toddler running around and playing with her friends. On initial assessment and CT scan she was found to have raised intracranial pressure secondary to progressive hydrocephalus of uncertain origin. Following consultation with a neurosurgeon in the tertiary hospital over 100km away, it was agreed that Nomusa required operative intervention and the insertion of a ventriculo-peritoneal (VP) shunt to relieve the pressure.

The need for an operation was discussed with Nomusa's mom who in turn consulted her husband and his family. Whilst she was keen for Nomusa to receive active management she was not prepared to provide consent for the operation as neither her husband nor his parents supported this option. Despite repeated counselling by doctors, nurses and the hospital social workers and in spite of what appeared to be a good understanding of the implications of this decision for Nomusa, her mother remain adamant that she could not give the necessary consent.

Whilst the operation was urgent, the neurosurgeons felt Nomusa's condition had not yet reach the point of causing permanent disability and that there was sufficient time in which to persuade the mother and family to consent to the operation. They were therefore not willing to proceed with consent from the hospital superintendent in lieu of parental consent. It was a Friday afternoon and the paediatric staff was now faced with a stalemate. They could not obtain consent as Nomusa's mother was not willing to defy her family and they were unable to speak to the family directly.

A decision was taken to pursue two courses simultaneously – to consult the Department of Health legal team regarding a petition for Ministerial consent in the face of what they perceived to be the unreasonable withholding of consent by the Nomusa's parents and to consult a member of the hospital's clinical ethics committee who is a traditional health practitioner. The legal team advised the clinicians to prepare reports that documented Nomusa's clinical state, management options and the likelihood of permanent harm should the operation not proceed. The paediatric staff sat down to prepare the necessary reports.

In the meantime the traditional healer consulted with Nomusa's mom and then travelled to the family's home more than 75 kms from the hospital. Whilst we are not sure of the details of the consultation between the traditional healer and the family, the outcome was that the family revised their decision and agreed to allow the operation to proceed.

6.11 Who can consent to treatment or surgery in a medical emergency?

The superintendent or person in charge of the hospital (in the absence of the superintendent) can consent to treatment or surgery for a child in a medical emergency. This refers to a situation where:

a) treatment or surgery is needed to save the child's life or prevent serious physical injury or disability; and
b) it is so urgent there is not enough time to obtain the necessary consent from the person who is authorised to consent.

Both requirements must be met in order to comply with the Act.

CASES FROM THE FIELD

Prof Andrew Argent (Red Cross War Memorial Children's Hospital)

A 13-year-old-girl was admitted to the hospital following a motor vehicle accident in which her mother had been killed and her father had been admitted to another hospital – unconscious with a significant head injury. On arrival at the hospital she was unconscious, intubated and ventilated, and had evidence of severe intra-abdominal trauma which required urgent surgical intervention to control bleeding. She had been brought into the hospital by ambulance and was not accompanied by any relatives.

While investigations such as computerised tomography of her brain and abdomen were being completed, the hospital medical superintendent was approached for consent for an urgent laparotomy and possible cranial surgery (to release a subdural haematoma and place intra-cranial monitoring devices). Consent for surgery and anaesthesia was provided by the medical superintendent and she was taken to theatre. A subdural haematoma was released and the intra-cranial monitoring devices were placed. During the laparotomy, bleeding was controlled with considerable difficulty and surgery was limited to damage control. She was returned to the paediatric intensive care unit with abdominal packs in place and stabilized on ventilation with inotropic support.

Subsequently relatives arrived at the hospital and they were informed of the situation. At that stage her father remained confused and was not competent to provide consent. After discussion with her family, consent for relook laparotomy was again provided by the medical superintendent and she returned to theatre where the surgeons were able to definitively control any sites of haemorrhage and close her abdomen. She subsequently made a full recovery.

What is an emergency?

The superintendent of a hospital or person in charge of the hospital can only consent in emergencies if the operation is necessary to preserve the child's life and it is so urgent that it cannot be deferred (postponed) for the purpose of obtaining parental or other consent.

Necessity + urgency = emergency

On the question of urgency the issue of "deferment" or postponement is essential to determine if the superintendent or person in charge of the hospital can give consent. Three scenarios can be distinguished:

If the parents or guardians are unavailable or cannot be traced and the surgery is so urgent that it cannot be delayed in order to acquire parental consent or ministerial consent, then the superintendent or person in charge of the hospital can give consent.

If a parent or guardian is present at the hospital and they refuse to consent to the surgery, but the surgery is so urgent that it cannot be postponed in order to obtain Ministerial or court ordered consent to override the refusal, then the superintendent or person in charge of the hospital can give the necessary consent

If a parent or guardian is present and they refuse to consent to the surgery, but the surgery is not so urgent that it cannot be delayed for a few days so as to get ministerial or court ordered consent to override the refusal, then the superintendent of the hospital or person in charge cannot give the consent. In such a case the Minister or the courts have to be approached in order to get the necessary consent before the health practitioner can go ahead with the surgery.

7. WHAT HAPPENS IN CASES OF ABUSE AND NEGLECT?

The right to protection in South African Law

As highlighted earlier the Constitution grants everyone – including children – the right to freedom and security of the person. This right includes the right to be free from all forms of violence from either public or private sources; the right not to be tortured in any way; and the right not to be treated or punished in a cruel, inhumane or degrading way. The children's clause (Section 28) in the Constitution also gives every child the right to be protected from maltreatment, neglect, abuse or degradation. The Children's Act aims to give effect to these rights by putting measures in place that are meant to ensure that children are protected from all forms of harm. This includes the creation of legal obligations like the duty to report abuse and neglect. Such duties to report can be found in both the Children's Act as well as the Criminal Law Sexual Offences Amendment Act 32 of 2007 (referred to as the Sexual Offences Act).

The Children's Act also attempts to create clarity around the meaning of terms like abuse, sexual abuse and neglect and provides definitions for these terms as follows:

In relation to a child, abuse means any form of harm or ill-treatment deliberately inflicted on a child, and includes:

(a) assaulting a child or inflicting any other form of deliberate injury to a child;

(b) sexually abusing a child or allowing a child to be sexually abused;

(c) bullying by another child;

(d) a labour practice that exploits a child; or

(e) exposing or subjecting a child to behaviour that may harm the child psychologically or emotionally.

In relation to a child, sexual abuse means:

(a) sexually molesting or assaulting a child or allowing a child to be sexually molested or assaulted;

(b) encouraging, inducing or forcing a child to be used for the sexual gratification of another person;

(c) using a child in or deliberately exposing a child to sexual activities or pornography; or

(d) procuring or allowing a child to be procured for commercial sexual exploitation or in any way participating or assisting in the commercial sexual exploitation of a child.

Neglect in relation to a child means:

A failure in the exercise of parental responsibilities to provide for the basic physical, intellectual, emotional or social needs of the child.

7.1 The obligation to report abuse and neglect

The obligations to report abuse and neglect are set out in section 110 of the Children's Act which states the following:

Who must report?

Any correctional official, dentist, homeopath, immigration official, labour inspector, legal practitioner, medical practitioner, midwife, minister of religion, nurse, occupational therapist, physiotherapist, psychologist, religious leader, social service professional, social worker, speech therapist, teacher, traditional health practitioner, traditional leader or member of staff or volunteer worker at a partial care facility, drop-in centre or child and youth care centre who: on reasonable grounds concludes that a child has been abused in a manner causing physical injury, sexually abused or deliberately neglected, must report that conclusion in the prescribed form to a designated child protection organisation, the provincial department of social development or a police official.

The Act improves on the reporting obligations which were set out in the previous Child Care Act by spelling out in more detail which professionals are obliged to report the sexual abuse, physical abuse and deliberate neglect of a child.

What must you report?

If you are one of the professionals listed in section 110 you must report:

- physical abuse causing injury;
- sexual abuse; and
- deliberate neglect.

Section 28 of the Prevention of and Treatment for Substance Abuse Act states that the reporting requirements in section 110 of the Children's Act apply to children abusing substances or affected by substance abuse.

Regulation 35 (2) and Form 22 list possible indicators of physical abuse, sexual abuse and neglect. The indicators are not exhaustive but cover physical signs and symptoms, emotional and behavioural indicators, developmental indicators and disclosure. All professionals working with children should familiarise themselves with the indicators in Regulation 35.

When must you report?

This report must be based on an actual conclusion that abuse or neglect occurred, and not merely a suspicion of abuse or neglect. The conclusion must be based on reasonable grounds which are established by the presence of indicators and factors prescribed in Regulation 35 (2). However this does not mean that one's suspicions must be ignored. It simply means that when abuse or neglect is suspected, then the reporter must look to the Regulations to get guidance on which indicators to consider in coming to a conclusion whether or not a child has been abused or neglected.

Regulation 35 sets out the following signs to consider when assessing if a child has been abused or neglected:

- signs of physical abuse include *"bruises in any part of the body; grasp marks on the arms, chest or face; variations in bruising colour; black eyes; belt marks; tears around or behind the ears; cigarette or other burn marks; cuts; welts; fractures; head injuries; convulsions that are not due to epilepsy or high temperature; drowsiness; irregular breathing; vomiting; pain; fever or restlessness"*;

- emotional and behavioural signs of physical, psychological or sexual abuse include *"aggression; physical withdrawal when approached by adults; anxiety; irritability; persistent fear of familiar people or situations; sadness; suicidal actions or behaviour; self-mutilation; obsessive behaviour; neglect of personal hygiene; age of child demonstrating socially inappropriate sexual behaviour or knowledge; active or passive bullying; unwillingness or fearfulness to undress or wearing layers of clothing"*;

- developmental signs of physical, psychological or sexual abuse include *"failure to thrive; failure to meet physical and psychological developmental norms; withdrawal; stuttering; unwillingness to partake in group activities; clumsiness; lack of coordination or orientation or observable thriving of children away from their home environment"*;

- signs of deliberate neglect include *"underweight; reddish scanty hair; sores around the mouth; slight water retention on the palm or in the legs; extended or slightly hardened abdomen; thin and dry skin; dark pigmentation of skin, especially on extremities; abnormally thin muscles; developmental delay; lack of fatty tissue; disorientation; intellectual disability; irritability; lethargy, withdrawal, bedsores and contractures"*;

- *"a disclosure of abuse or deliberate neglect by the child"*; or

- *"a statement relating to a pattern or history of abuse or deliberate neglect from a witness relating to the abuse of the child"*.

In deciding whether a child has been abused or neglected, the Act requires that these signs or indicators be considered in the *"total context of the child's situation".* This means that the focus should not fall on only one factor or indicator.

Where must you report?

Once a conclusion is reached that there was abuse or deliberate neglect, it must be reported to one of three agencies: a designated child protection organisation, the provincial Department of Social Development or a police official.

CASES FROM THE FIELD

Dr Neil McKerrow (Department of Health, KwaZulu-Natal)

Ntombifuthi is a five-year-old girl who lives with her brother, her mother, an uncle and her grandfather in the grandfather's house. Ntombi's mother is unemployed and looking for work so is dependent on her brother who is the only adult in the household with an income. Both her uncle and her grandfather drink excessively and are reportedly regularly drunk.

For the past nine months Ntombi has been attending a crèche. Her class teacher describes her as a quiet, withdrawn child with abnormal behaviour as she frequently crawls beneath her desk where she draws pictures which she then scribbles over with a black crayon.

Ntombi was brought to the hospital by her mother for assessment of a purulent vaginal discharge. Given her poor social circumstances, Ntombi's abnormal behaviour at crèche and her vaginal discharge the attending paediatrician was concerned about the possibility of sexual abuse. She raised this possibility with Ntombi's mother and requested permission to do a genital assessment. Ntombi's mother was not surprised by the suggestion that her daughter may have been sexually abused nor did she dismiss the possibility that the perpetrator was a member of the household. However she was not willing to consent to a genital assessment as she was dependent on the household for shelter and food. She felt that although Ntombi's behaviour was a bit bizarre she would grow out of this and so just wanted treatment for the discharge.

Working out how to proceed was difficult, without consent an examination could not be conducted. The paediatrician consulted with colleagues and finally decided to err on the side of overtreatment rather than miss the opportunity to prevent sequelae. Mum, who was concerned about the health of the child, consented to treatment, prophylaxis and counselling.

The paediatrician reported the case to the police to trigger a criminal investigation, warning the policer officer that the mother had refused an examination; and believing that the mother could not protect the child she also called social services to conduct an emergency removal.

What forms must the health professional complete?

Form 22 (on page 84) is used to report a case of abuse or neglect to an appropriate authority to trigger a child protection investigation by a designated social worker. The form should be completed by the health professional. The J88 is used as evidence in the criminal investigation. The investigating officer will supply this form along with the SAPS 308 (which provides consent for an examination in a criminal case).

Who can consent to examination in cases of suspected child abuse and neglect?

The national instruction given to police officials states:

> *If the victim of the alleged sexual offence is a child, the investigating officer must explain the necessity of the examination to the parents or guardian of the child and obtain their consent for the examination to be performed and complete form SAPS 308.*[27]

The instruction further states that if consent cannot be obtained from the parents or guardian then an application must be made to a magistrate for consent to conduct the medical examination. In addition, the Children's Act states that the child must consent for the examination:

> *A child must, prior to his or her being examined or assessed for purposes of establishing whether such child has been abused or neglected, consent, either verbally or in writing, to the assessment or examination if such child is of sufficient maturity and has the mental capacity to understand the reasons for the examination or assessment: Provided that an assessment or examination may proceed in the absence of a child's consent if it is deemed to be in the best interests of such child, in which case the reasons for proceeding with the assessment or examination must be noted in writing by the person doing the assessment or examination and explained to the child and to his or her parent, guardian or caregiver.*[28]

The investigating officer is responsible for getting consent from the parents, whereas the health professional is responsible for getting consent from the child.

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[27] South African Police Service (2008) *National Instruction 3/2008 Sexual Offences*. Section 10 (8)(a).
[28] Regulation 38 (2).

Although, the law allows a medical assessment without the child's consent this is subject to such examination being in the best interest of the child. In virtually all cases of sexual abuse the child will have been manipulated or coerced into having sex. As a result the child is highly likely to be emotionally conflicted and traumatised. Given the nature of the medical assessment risk of secondary trauma is extremely high. The role of the doctor is to put the needs of the child first and to ensure that they do not contribute to secondary trauma. Treatment can be given without an assessment. After 12 hours the chance of finding forensic evidence from a young child are mininal[29] so the benefits rarely, if ever, outweigh the potential harm to the child.

7.2 What are the key differences between the Children's Act and the Sexual Offences Act in respect of reporting of sexual abuse?

The reporting obligations outlined in section 110 of the Children's Act, appear to be more flexible than the reporting obligations stemming from the Sexual Offences Act.

- While the Children's Act requires a conclusion of abuse or neglect, the Sexual Offences Act simply requires knowledge of an offence to trigger the reporting obligation.
- While under the Children's Act only certain professionals are obliged to report, under the Sexual Offences Act any person who has knowledge is obliged to report.
- Under the Children's Act health professionals can report abuse to social services or the police, while the Sexual Offences Act requires health workers to report offences to the police.

Health professionals need to look out for different factors when applying the reporting obligations for these two laws.

The table in Appendix B outlines the compulsory reporting obligations outlined the Children's Act and the Sexual Offences Act, and spells out:

- who must report;
- what must be reported;
- who to report to;
- the procedures for reporting and investigating the alleged abuse and protecting the child; and
- the consequences and penalties of not reporting.

[29] Christian, CW, Lavelle, JM, de Jong, AR, Loiselle J, Brenner, L & Joffe, M, (2000) Forensic Evidence Findings in Prepubertal Victims of *Sexual Assault, Pediatrics*, 106(1): 100-104; and Young, KL, Jones, JG, Worthington, T, Simpson P, Casey PH (2006) Forensic Laboratory Evidence in Sexually Abuse Children and Adolescents, *Arch Ped Adoles Med*, 160(5): 585–588.

Voluntary reporting

The compulsory reporting obligation applies only to sexual abuse, physical abuse causing injury and deliberate neglect; however, there are many other circumstances that may leave a child in need of care and protection. The full list is given in section 150 (1), which provides that a child is considered to be in need of care and protection if the child:

- has been abandoned or orphaned and without visible means of support;
- displays behaviour that cannot be controlled by the parent;
- lives or works on the street or begs for a living;
- is addicted to a substance and without support to obtain treatment;
- is exploited or lives in circumstances that expose her to exploitation;
- lives in or is exposed to circumstances which may seriously harm his physical, mental or social well-being;
- may be at risk if returned to the custody of the parent as there is reason to believe that she will live in or be exposed to circumstances which may seriously harm her physical, mental or social well-being;
- is in a state of physical or mental neglect; or
- is being maltreated, abused, deliberately neglected or degraded by a parent or caregiver.

If you find a child in any of these circumstances you can make a voluntary report. As with compulsory reporting you should complete a Form 22 and submit it to a designated child protection organisation (e.g. Child Welfare), the provincial Department of Social Development, or a police official. Once they receive the form a social worker will be assigned to do an investigation into the circumstances of the child and family and compile a report which must be submitted to the children's court.

7.3 Should a child's right to protection from violence, abuse or neglect override his or her right to privacy and confidentiality? If so, when?

Children's rights cannot be understood in terms of a hierarchy of importance – they are all inter-dependent. To realise one right often involves the simultaneous realisation of another. However, at times there can be a tension between the realisation of different rights. According to section 13 of the Children's Act, every child has a right to *"confidentiality regarding his or her health status and the health status of a parent, caregiver or family member, except when maintaining such confidentiality is not in the best interests of the child"*. This section acknowledges the child's general right to confidentiality and at the same time acknowledges the limitation of such a right. It is not in a child's best interest to maintain confidentiality when a child has been abused or neglected.

A health care professional has a legal obligation to report cases of abuse and neglect to the appropriate authorities, even where the child is adamant that he or she does not want the information to be taken further. In such circumstances, it is important to be clear with the child about the boundaries of confidentiality, what the law says, and to involve the child as far as possible in deciding how and when the information will be reported. The reasons for overriding the child should be clearly explained, and he or she should be kept as fully informed as possible throughout the process. It is important to remember that violence and abuse of children serves to disempower them. It is therefore vital that the strategies adopted to protect them should not further disempower them. Any action must take account of the child's individual circumstances and context. A "one size fits all" approach should never be adopted.

A similar limitation on the right to confidentiality can also be found in section 134(3) regarding children accessing contraceptives. In that section the Act notes that the child who obtains condoms, contraceptives or contraceptive advice in terms of this Act is entitled to confidentiality in this respect, subject to section 110. So if the health provider who is giving a child contraceptives, condoms or contraceptive advice, concludes that there was abuse then the health provider should report the matter.

7.4 Sexual Offences Act: Constitutional Court rules that criminalisation of consensual sex between adolescents is unconstitutional

Sexual experimentation by adolescents is a normal part of growing up. However, adolescents' health and well-being may be at risk if they engage in sexual activity without the necessary knowledge about contraception, STIs and HIV, and before they are mature enough to understand and handle the emotional and health consequences. It is in the best interests of children to minimise these risks; the question is how?

The Sexual Offences Act[30] makes it an offence for children aged 12 – 15 to engage in consensual sexual acts (ranging from kissing to penetration). The Act obliges adults to report a known sexual offence to the police – even if those involved are consenting adolescents.

[30] Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007.

The High Court case

The constitutionality of the provisions in the Sexual Offences Act was challenged by the Teddy Bear Clinic and Resources Aimed at the Prevention of Child Abuse and Neglect (RAPCAN) in the North Gauteng High Court and then in the Constitutional Court on the grounds that they do not serve the best interests of children. These organisations argued that criminalising adolescents for engaging in developmentally normal behaviour is an extreme measure that not only violates their rights but may also prevent them from approaching their parents, educators, social workers, nurses and other support people for guidance, information, contraception and treatment of STIs and HIV. The expert report stated that the provisions also inhibit adult support putting children at increased risk:

> *Caregivers…and institutions and organisations…are unable to help because they cannot promote behaviour that is illegal and they are legally obligated to report sexual offences involving children and young adolescents… Therefore, they cannot legally offer the adequate and appropriate support and guidance to promote healthy sexual development, which leaves adolescents to navigate the complex issues with only the support of their equally immature peers.*[31]

In response to this challenge the Department of Justice and Constitutional Development (DoJ&CD) defended the criminalisation of consensual sexual activity between adolescents. Based on the assumption that the law acts as a deterrent, the DoJ&CD claimed that the prohibition protects *"the bodily and psychological integrity of adolescents by delaying their choice on matters which may have a harmful consequence"*[32] and that *"parents, guardians and other responsible adults will be empowered to drive the message of risks of early sexual intimacy through these prohibitions"*[33]. The department further argued that *"there are no other less restrictive means to achieve the purpose of the prohibitions"*.[34]

[31] Flisher A and Gevers A (2012) *Expert Opinion in the matter Teddy Bear Clinic for Abused Children and RAPCAN v Minister of Justice and Constitutional Development and Another,* CCT 12/13.
[32] Minister of Justice and Constitutional Development (2013) *Respondent's Heads of Argument in the matter Teddy Bear Clinic for Abused Children and RAPCAN v Minister of Justice and Constitutional Development and Another*, CCT 12/13. Para 44.
[33] See no. 32 above, para 91.3.
[34] See no. 32 above, para 94.

Research has shown that a mandatory reporting and abstinence-only approach is not an effective deterrent. However *"comprehensive sex education programmes have shown an increased likelihood in delaying sexual initiation and reduced likelihood of teen pregnancy"*.[35] All adolescents should therefore be offered appropriate education and guidance on sexual and reproductive health from their parents and caregivers, schools and health care facilities.

The High Court judgment

In the High Court judgment, Justice Rabie noted that all the parties to the case, including the Minister (even though he had opposed the application), agreed that *"it is a common and normal part of sexual development for children to explore and experiment in sexual behaviours with their peers"*.[36] The court found that the Act constitutes an *"unjustified intrusion of control into the intimate and private sphere of children's relationships in a manner that will cause severe harm"*[37] and declared that the criminalisation of consensual teenage sexual activity, and consequent reporting to the police, violate a number of constitutional rights. These include the best interests' principle, dignity, bodily and psychological integrity, and privacy. In finding the provisions unconstitutional, the court concluded that *"[t]he use of damaging and draconian criminal law offences to attempt to persuade adolescents to behave responsibly is a disproportionate and ineffective method which is not suited to its purpose"*.[38]

The Constitutional Court judgment

As the case concerned a declaration of unconstitutionality of an Act of Parliament, it had to be confirmed by the Constitutional Court. The Constitutional Court considered the narrow question of whether *"it is constitutionally permissible for children to be subject to criminal sanctions in order to deter early sexual intimacy and combat the risks associated therewith"*.[39] The Constitutional Court handed down judgment on 3 October 2013 confirming the order of unconstitutionality, and sending the Sexual Offences Act back to Parliament for revision. The Court found that the sections constitute a "deep" encroachment on the rights to human dignity and privacy, as well as the best-interests principle:

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[35] Gevers A, Mathews C, Cupp P, Russell M & Jewkes R (2013) Ilegal yet developmentally normative: A descriptive analysis of young, urban adolescents' dating and sexual behaviour in Cape Town, South Africa. *BMC International Health and Human Rights*, 13:31.

[36] *Teddy Bear Clinic for Abused Children and Others v Minister of Justice and Constitutional Development and Others*. Case no: 73300/10 North Gauteng High Court, 14 January 2013. Para 100.

[37] See no. 36 above, para 74.

[38] See no. 36 above, paras 112, 113 and 121.

[39] *Teddy Bear Clinic for Abused Children and RAPCAN v Minister of Justice and Constitutional Development and Another* CCT 12/13 [2013] ZACC 35. Para 3.

> *It cannot be doubted that the criminalisation of consensual sexual conduct is a form of stigmatisation which is degrading and invasive... If one's consensual sexual choices are not respected by society, but are criminalised, one's innate sense of self-worth will inevitably be diminished.*[40]

Rights always have to be balanced and in terms of section 36 of the Constitution it is sometimes permissible to limit one right to give effect to another. However, a right cannot be limited if less restrictive means can achieve the same ends; it *"does not permit a sledgehammer to be used to crack a nut."*[41]

In this case the Constitutional Court found that the infringements on children's rights to dignity and privacy could not be justified in the name of protecting adolescents from psychological harm, sexually-transmitted diseases and pregnancy, because there were less restrictive and more effective means to reduce the risk of adolescents engaging in unhealthy sexual activities. The Court noted that *"the reporting provisions are likely to create an atmosphere in which adolescents will not freely communicate about sexual relations with parents and counsellors."*[42]

> *What is of utmost importance is ensuring that children are appropriately supported by the adults in their lives, to enable them to make healthy choices. If children are not made to feel that there are safe environments within which they can discuss their sexual experiences, they will be stripped of the benefit of guidance at a sensitive and developmental stage of their lives.*[43]

A moratorium on reporting

The Court ordered a moratorium on all investigations into, arrests of, and criminal and ancillary proceedings against adolescents in relation to sections 15 and 16 of the Sexual Offences Act until such time as Parliament amends the Act. *"This moratorium will put in abeyance any related reporting obligations which may otherwise have arisen from the operation of section 54 of the Act."*[44]

This means that health professionals do not have to report consensual sexual acts between adolescents (children between the ages of 12 and 15). However, it needs to be stressed that it is still an offence for adults and 16-17 year olds to have sex with younger adolescents, and any form of sexual abuse must be reported.

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[40] See no. 39 above, para 55.
[41] *S v Manamela and Another (Director-General of Justice Intervening)* [2000] ZACC 5; 2000 (3) SA 1 (CC); 2000 (5) BCLR 491 (CC) at para 34.
[42] See no. 39 above, para 73.
[43] See no. 39 above, paras 45.
[44] See no. 39 above, para 111.

8. CONCLUSION

The United Nations Committee on the Rights of the Child encourages us to recognise that children are rights holders.[45] As such, governments must put in place policies, laws and programmes to promote and enable the realisation of rights for all children. The Children's Act has been written in line with the UNCRC, other international laws, and the South African Constitution. It is an important piece of legislation that sets out new requirements and opportunities for health professionals to improve the quality of care for children.

The Children's Act makes it clear that health professionals have a legal obligation to involve children in health care decision-making. Realising children's right to participate requires changes in practice. This includes providing child-friendly information; taking time to listen to children; taking their views seriously; respecting children's evolving capacities and their entitlement to consent to their own health care services in accordance with the provisions of the Children's Act; and respecting their privacy and confidentiality. These changes need to be integrated into the training of health professionals and codes of professional practice.

Health professionals also have a duty to protect children from harm, and are legally required to report cases of abuse and neglect for further investigation.

[45] United Nations Committee on the Rights of the Child (2006) *Convention on the Rights of the Child. General Comment No. 7 (2005). Implementing child rights in early childhood.* Geneva: UNCRC.

APPENDIX A: CHILD CONSENT PROVISIONS IN THE CHILDREN'S ACT AND OTHER LEGISLATION

Consent provisions in the Children's Act

HEALTH SERVICE	AGE AT WHICH A CHILD CAN CONSENT	ADDITIONAL REQUIREMENTS
Medical treatment (including psychiatric and psychological treatment)	12 years or older This includes consent to the treatment of his or her child (in the case of a child parent).	The child must also be of sufficient maturity and have mental capacity to understand benefits, risk, social and other implications of the treatment.
Surgical operations (including medical circumcision)	12 years or older This includes consent to the treatment of his or her child (in the case of a child parent).	The child must also be of sufficient maturity and have mental capacity to understand benefits, risk, social and other implications of the treatment; and He/she must be assisted by a parent or a guardian.
HIV testing	Any child of 12 years or older can consent Children younger than 12 must meet the additional requirements.	If the child is younger than 12 then he/she must undergo a maturity assessment. A child must undergo pre- and post test counselling. A child cannot be tested for HIV unless it is in the child's best interest and the necessary consent has been obtained or the test is necessary because: (a) it is suspected that a health worker was exposed to HIV after having contact with bodily substances of the child which could have transmitted HIV during a medical procedure, or (b) someone who had contact with the bodily substances of the child could have been exposed to HIV. In this case the test has to be authorised by a court.

Disclosing a child's HIV-positive status	12 years or younger	If the child is younger than 12 then he/she must undergo a maturity assessment. No-one may disclose that a child is HIV positive unless the necessary consent is obtained from the child or other persons authorised to consent on behalf of the child. A person may only disclose a child's HIV-positive status without consent if such disclosure: • falls within that person's powers and duties under the Act; • is necessary in order to carry out the provisions of the Act; • is necessary for legal proceedings; or • is authorised by a court.
Contraceptives	12 and older	There is no general maturity assessment required for a child to access contraceptives, but for contraceptives other than condoms (like the pill or injection) the child must be given medical advice and must be examined before contraceptives can be provided.
Female circumcision	Prohibited at any age	
Male medical circumcision	12 years or older	The child must **also** be of sufficient maturity and have the mental capacity to understand benefits, risk, social and other implications of the treatment; and he must be assisted by a parent or a guardian.
Virginity testing	16 years or older	After proper counselling.

Consent provisions in the Choice on Termination of Pregnancy Act

Termination of Pregnancy (TOP)	No specific age limit	The child must be able to give valid consent: meaning the child must have maturity and mental capacity to understand benefits, risk, social and other implications of the TOP.

Consent provisions in the Mental Health Care Act

Mental Health Care Services	No specific age limit	The Act states that the user must give consent. It also states that where the person receiving services is under 18, the following people may be considered a user: • the child's next of kin; or • a person authorised by any other law or court order to act on that person's behalf.

Consent provisions in the Prevention of and Treatment for Substance Abuse Act

Voluntary admission to a treatment centre	Persons under 18 cannot apply to be admitted at a facility in order to receive treatment for substance abuse.	A parent or guardian can apply for the child to be admitted.

Involuntary admission	No specific age limit	In an emergency a police official or a designated social worker may remove a child from the care of his/her parents and admit the child to a treatment centre or child and youth care centre offering a substance abuse programme. The court must review this removal within 48 hours. In other circumstances there must be a full investigation and a children's court inquiry before a child can be placed in a treatment centre as an involuntary.

Consent provisions in the Sterilisation Act

Sterilisation	18 years or older	Under 18 years sterilisation may be performed only if: • failure to do so would jeopardise the child's life or seriously impair his or her health; • the parent or guardian consents; • an independent medical professional who, has consulted with the child, has provided a written opinion to the effect that the sterilisation is in the best interest of that child; and • a panel of a psychiatrist, psychologist or social worker, and a nurse approve.

Consent provisions in the National Health Act

Blood donation	16 years or older	

APPENDIX B: COMPULSORY REPORTING OBLIGATIONS

LAW	CHILDREN'S ACT 38 OF 2005	CRIMINAL LAW SEXUAL OFFENCES AMENDMENT ACT 32 OF 2007
Relevant sections and regulations	Section 110, 305 General regulations regarding children (Government Gazette No. 33076 of April 2010) Regulation 33 & 35.	Section 54 National Instruction in terms of the Criminal Law (Sexual Offences and Related Matters) Amendment Act (No. 32 of 2007): For general information (Government Gazette No. 31330 of August 2008 Sections 4, 919).
Who must report?	Any correctional official, dentist, homeopath, immigration official, labour inspector, legal practitioner, medical practitioner, midwife, minister of religion, nurse, occupational therapist, physiotherapist, psychologist, religious leader, social service professional, social worker, speech therapist, teacher, traditional health practitioner, traditional leader or member of staff or volunteer worker at a partial care facility, drop-in centre or child and youth care centre.	Any person who has knowledge that a sexual offence has been committed against a child must report such knowledge immediately.

What must be reported?	The existence of reasonable grounds to conclude that a child has been abused in a manner causing physical injury, sexually abused or deliberately neglected. The Regulations provide a broad risk assessment framework to guide the assessment of risk factors that would be considered reasonable grounds for concluding abuse or neglect. The risk assessment framework also guides the investigation by the provincial Department of Social Development (DSD) or Designated Child Protection Organisation (DCPO).	Knowledge of a sexual offence committed against a child.
Who to report to?	The report must be sent to a DCPO, the provincial DSD or a police official.	The report must be made to a police official.

What is the procedure for reporting and investigation the alleged abuse and protecting the child?

The report must be done by completing Form 22 to the best of the reporter's ability and then sending it to the DCPO, the provincial DSD or a police official.

If the report is made to a police officer then the officer must ensure the safety and well-being of the child if the child's safety or well-being is at risk. The officer must then within 24 hours notify the provincial DSD or a DCPO of the report and anything done in relation to the child.

If the report is made to the DSD or the DCPO then:

- The child's safety must be ensured if it is at risk.
- An initial assessment of the report must be made.
- The truthfulness of the report must be investigated unless it is frivolous or obviously unfounded.
- If the report is substantiated, child protection procedures must be initiated in terms of the Act.
- The information and report must be sent to the Director General on Form 23 for inclusion on the National Child Protection Register.

If the report is made to a DCPO then the organisation must notify the DSD.

Once the report is made to the police official (it can be done telephonically or in person, no form seems to be prescribed), the police official must consider the information. If the police official is satisfied that there are reasonable grounds to believe that an offence was committed, then he or she must take an affidavit from the reporter, open a docket for investigation of the offence and register the docket on the system.

A trained member of the FCS Unit or a specialized individual must be contacted when it comes to child victims and if there are grounds for believing that it would be in the best interest of the child to remove him/her to a place of safety then the provisions of the Children's Act must be applied.

Once an investigating officer has been assigned to the matter, that officer must also ensure the safety of the child and that includes determining if the child is in need of care and protection. Also at this stage the matter can be referred to a designated social worker to investigate the circumstances of the child and see if the child is in need of care and protection and what services can be provided to the child.

What are the consequences and penalties of not reporting?	A person is guilty of an offence if that person fails to comply with the reporting obligation in section 110 (1). If that person is convicted then he/she is liable to a fine or to imprisonment for a period not exceeding ten years, or to both a fine and such imprisonment.	A person who fails to report knowledge of a sexual offence against a child is guilty of an offence and is liable on conviction to a fine or to imprisonment for a period not exceeding five years or to both a fine and such imprisonment.

FORM 1

CONSENT TO A VIRGINITY TEST BY A CHILD

(Regulation 3(1))

[SECTION 12(5) OF THE CHILDREN'S ACT 38 OF 2005]

PART 1: PARTICULARS OF CHILD AND OF PERSON PERFORMING VIRGINITY TEST

[Child to be aged 16 years or older]

Full name of child	
Date of Birth / ID number	
Residential address of child	
Telephone contact details	
Cell phone number	
Age of child (16 or older)*	

* Proof of age to be attached

Particulars of person administering virginity test

Name	
ID No (where applicable)	
Address	
Telephone contact details	
Cell phone number	

PART 2: PRE-TEST COUNSELING, AND ACQUISITION OF VOLUNTARY AND INFORMED CONSENT

I confirm that the child to undergo the virginity test has received proper counseling about the risks, benefits and social implications of a virginity test.

I confirm that I have received sufficient proof that the child to undergo virginity test is 16 years or older.

I have explained to the child consenting to treatment the following in language that is understandable to the child:

- The nature of the virginity test and method to be followed
- Any risks associated with a virginity test
- Any risks associated with a virginity test
- The social implications of virginity test
- Any other implications or possible consequences of a virginity test
- The confidential nature of the results of a virginity test
- The voluntary nature of the test

I have given the child an opportunity to ask questions relating to the above.

_____

Signature of person performing the virginity test

Date: _____ Place: _____

PART 3: CONSENT BY CHILD

I, ...(insert child's name)

- understand that a virginity test is going to be performed on me, and that I am voluntarily undergoing this test
- understand the risks and possible consequences of a virginity test that have been explained to me
- confirm that I have been given an opportunity to ask questions about a virginity test and the results of such a test
- consent to a virginity test but understand that I any at any time before the producer withdraw my consent

I understand that the results of the virginity test will be confidential unless I give my consent for the results to be disclosed.

I believe that I have sufficient information to give this informed consent.

_____

Signature of child

Date: _____

Place: _____

_____

Signature of witness

Date: _____ Place: _____

FORM 22

REPORTING OF ABUSE OR DELIBERATE NEGLECT OF CHILD

(Regulation 33)

[SECTION 110 OF THE CHILDREN'S ACT 38 OF 2005]

REPORTING OF ABUSE TO PROVINCIAL DEPARTMENT OF SOCIAL DEVELOPMENT, DESIGNATED CHILD PROTECTION ORGANISATION OR POLICE OFFICIAL

NOTE: A SEPARATE FORM MUST BE COMPLETED FOR EACH CHILD

TO: THE HEAD OF DEPARTMENT

_____

_____

_____

_____

Pursuant to section 110 of the Children's Act, 2005, and for purposes of section 114(1)(*a*) of the Act, you are hereby advised that a child has been abused in a manner causing physical injury/sexually abused/deliberately neglected or is in need of care and protection.

Source of report (do not identify person)

☐ Victim ☐ Relative ☐ Parent

☐ Neighbour ☐ Friend

☐ Professional (specify) _____

☐ Other (specify) _____

Date reported to child protection organisation:	DD	MM	CCYY

1. CHILD: (COMPLETE PER CHILD)						
Surname			Full name(s)			
Gender:	M	F	Date of Birth:	DD	MM	CCYY
School Name:			Grade:		Age/Estimated Age:	
* ID no:			* Passport no:			
Contact no:						

2. CATEGORY OF CHILD IN NEED OF CARE/PROTECTION			
☐ Child abuse	☐ Child labour	☐ Child trafficking	☐ Street child
☐ Commercial sexual exploitation	☐ Exploited children	☐ Child abduction	

3. OTHER INTERVENTION—CONTACT PERSON TRUSTED BY CHILD	
Surname:	Name:
Address:	Telephone number:
Other children interviewed: ☐ Yes ☐ No Number :	

(*) = Complete if available or applicable

4. CAREGIVER INFORMATION (If not same as trusted person or parent(s) of child)	
Surname:	Name:
Physical Address:	Postal Address:
Relationship with child:	
Telephone number:	Mobile:

5. ALLEGED ABUSER						
5.1) Surname				Full Name(s)		
Date of Birth:	DD	MM	CCYY	Gender:	M	F
ID No:				Age:		
* Passport No:				* Drivers license:		

Also known as*	Relationship to child: ☐ Father ☐ Mother ☐ Grandfather ☐ Grandmother ☐ Stepfather ☐ Stepmother ☐ Foster father ☐ Foster mother ☐ Uncle ☐ Aunt ☐ Sibling ☐ Caregiver ☐ Professional: social worker/police officer/teacher/caregiver/priest/Dr/volunteer ☐ Other (specify)
Street Address (include postal code):	

5.2) WHEREABOUTS OF ALLEGED PERPETRATOR:

☐ Section 153 (request for removal by SAPS) ☐ Still in home

☐ In hospital (Name/Place .....)

☐ In detention (Place .....)

☐ Living somewhere else

☐ Where abouts unknown ☐ Un-identified

6. PARENTS OF CHILD (If other than above)						
Surname: Father/Step-father				Full name(s)		
Date of Birth:	DD	MM	CCYY	Gender:	M	F
ID No:				Age:		
Surname: Mother/Step-mother				Full name(s)		

Date of Birth:	DD	MM	CCYY	Gender:	M	F
ID No:				Age:		
Also known as:				Names and ages of siblings or other children if helpful for tracking		
Street Address (include postal code):						Postal Code:

7. ABUSE

Date of Incident:			If date unknown (mark with X here):	Episodic/ongoing from (date)			Reported to CPR:		
DD	MM	CCYY		DD	MM	CCYY	DD	MM	CCYY

Place of incident:
- ☐ Child's home
- ☐ Field
- ☐ Tavern
- ☐ School
- ☐ Friend's place
- ☐ After school centre
- ☐ Neighbour
- ☐ ECD Centre
- ☐ Private Hostel
- ☐ Child and Youth Care Centre
- ☐ Foster home
- ☐ Temporary safe care
- ☐ Temporary respite care
- ☐ Other (specify)

7.1) TYPE OF ABUSE (Tick only the one that indicates the key motive of intent)

Physical	Emotional	Sexual	Deliberate neglect

7.2) INDICATORS (Check any that apply)

PHYSICAL:

- ☐ Abrasions
- ☐ Bruises
- ☐ Burns/Scalding
- ☐ Fractures
- ☐ Other physical illness
- ☐ Cuts
- ☐ Welts
- ☐ Repeated injuries
- ☐ Fatal injury (date of death)
- ☐ Injury to internal organs
- ☐ Head injuries
- ☐ No visible injuries (elaborate)
- ☐ Poisoning (specify)
- ☐ Other Behavioural or physical (specify)

EMOTIONAL:

- ☐ Withdrawal
- ☐ Depression
- ☐ Self destructive aggressive behaviour
- ☐ Corruption through exposure to illegal activities
- ☐ Deprivation of affection
- ☐ Exposure to anti-social activities
- ☐ Exposure to family violence
- ☐ Inappropriate and continued criticism
- ☐ Parent or caregiver negative mental condition
- ☐ Humiliation
- ☐ Isolation
- ☐ Threats
- ☐ Development Delays
- ☐ Oppression
- ☐ Rejection
- ☐ Accusations
- ☐ Anxiety
- ☐ Lack of cognitive stimulation
- ☐ Mental, emotional or developmental condition requiring treatment (specify)

SEXUAL:

- ☐ Contact abuse
- ☐ Rape
- ☐ Sodomy
- ☐ Masturbation
- ☐ Oral sex area
- ☐ Molestation
- ☐ Non contact abuse (flashing, peeping)
- ☐ Irritation, pain, injury to genital
- ☐ Other indicators of sexual molestation or exploitation (specify)

DELIBERATE NEGLECT:

☐ Malnutrition ☐ Medical ☐ Physical
☐ Educational ☐ Refusal to assume parental responsibility
☐ Neglectful supervision ☐ Abandonment

7.3) Indicate overall degree of Risk to child:

☐ Mild ☐ Moderate ☐ Severe ☐ Unknown

7.4) When applicable, tick the secondary type of abuse or multiple abuse:

☐ Yes ☐ No

Physical	Emotional	Sexual	Deliberate neglect

Brief explanation of occurrence(s) including a statement describing frequency and duration

_____

_____

_____

_____

8. MEDICAL INTERVENTION (*)			
Examined by: ☐ Doctor ☐ Reg. Nurse	Treatment received: ☐ Yes ☐ No	Where (name of hospital, clinic, private doctor):	Hospitalised: ☐ For assessment ☐ For treatment ☐ As temporary safe care (place of safety)
Contact person:	Contact person:	Contact person:	Contact person:

Telephone Number:	Telephone Number:	Telephone Number:	Telephone Number:

9. CHILDREN'S COURT INTERVENTION (*)			
Removal of child to temporary safe care (Section 152): ☐ Yes ☐ No	Date		
	DD	MM	CCYY

10. SAPS: (ACTION RELATED TO ALLEGED ABUSER(S)) – (*)				
Reported to SAPS: ☐ Yes ☐ No	Charges laid: ☐ Yes ☐ No	Date		
		DD	MM	CCYY
CASE Nr	Police Station	Telephone Nr		
Name of Police Officer		Rank of Police Officer		

11. CHILD KNOWN TO DESIGNATED CHILD PROTECTION ORGANISATIONS (DCPO)/ SOCIAL DEVELOPMENT (DSD)?		
11.1) Child known to DCPO/DSD office:	Contact number	Reference number

12. DETAILS OF PERSON WHO REPORTS ALLEGED ABUSE (Refers to a professional or mandatory obliged to report child abuse in terms of Section 110 (1))					
CAPACITY (OF INFORMANT)					
Caregiver	Correctional officer	Child and Youth Care Centre	Dentist	Doctor	Drop in Centre
Homeopath	Labour Inspector	Legal Practitioner	Midwife	Member of staff—partial care facility	Medical Practitioner
Minister of Religion	Nurse	Occupational Therist	Psychologist	Police Official	Physio-therapist
Religious Leader		Social Service Professional		Social Worker	
Speech Therapist		Shelter		Traditional Leader	
Teacher		Traditional Health Practitioner		Volunteer Worker—Partial Care Facility	
Other (specify)					
Surname of informant		Name of informant		Name of employer	
Employer Address		Work Telephone Nr		Fax Number	
Email Address					

(*) = Complete if information is available or applicable

I declare that the particulars set out in the above mentioned statement are true and correct to the best of my knowledge.

Signature of informant: _____

Date: _____

Official Stamp

FORM 29

INQUIRY BY EMPLOYER TO ESTABLISH WHETHER PERSON'S NAME APPEARS IN PART B OF NATIONAL CHILD PROTECTION REGISTER

(Regulation 44)

[SECTION 126 OF THE CHILDREN'S ACT 38 OF 2005]

TO: The Director- General
Department of Social Development
Private Bag X901
PRETORIA
0001

Dear Sir / Madam,

In terms of section 126(1) / 126 (2)* of the Children's Act, (No. 38 of 2005), I, ...(full names and surname) wish to inquire whether the name of a certain person is included in Part B of the National Child Protection Register. The particulars of the person are:

(* - Delete which is not applicable)

1. EMPLOYEES DETAILS:						
Surname			Full Name (s)			
Gender:	M	F	Date of Birth	DD	MM	CCYY
* He / she is known as:			Driver's licence no:			
Alias (also known as):						

* ID no:	* Passport no:
Physical Address:	Postal Address:
Telephone no:	Mobile no:
The above-mentioned person will be / is currently * employed in the following position:	

2. DETAILS OF EMPLOYER – (My/our details are the following:)	
Employee's name or name of NPO	NPO Registration number:
Employers Physical Address:	Employer's Postal Address:
Employer's telephone no/s:	Other contact details:

3. ATTACHED DOCUMENTS

A certified copy of the following documents is attached as verification of identity:

- ☐ authentic signed letterhead of employer or prospective employer
- ☐ certified copy of birth certificate, identity document or passport of person who signed letterhead
- ☐ certified copy of birth certificate, identity document or passport of person to be screened

Please note that section 126(5)(a) of the Act requires you to respond to this inquiry within 21 working days.

Your sincerely

_____ _____

(Signature) (Designation)

_____

(Date)

Official Stamp of employer / Organisation

FORM 33

APPLICATION FOR CONSENT TO MEDICAL TREATMENT OR SURGICAL OPERATION BY MINISTER

(Regulation 47)

[SECTION 129(7) OF THE CHILDREN'S ACT 38 OF 2005]

Part A: Details concerning the applicant, the child, the particulars of the person/ institution providing medical treatment or performing the surgical operation and the parent/ guardian assisting the child.

Full name of child	
Date of birth/ ID number/passport number*	
Address of child	
Contact details	
Age of child	

* Please attach copy of birth certificate/ ID Number / Passport where applicable

Applicant details

Full name of applicant	
Date of Birth/ID number/ Passport number*	
Address of child	
Contact details	
Relationship to child/ official designation/ other details explaining why applicant in this matter	

Particulars of person/hospital/clinic/surgery/ other institution* providing medical treatment/performing surgical operation

Name	
Practice no/hospital/clinic/surgery/staff position	
Address	
Contact details	
Nature of surgical procedure	
Details of other institution performing surgical operation *	

* Please furnish details concerning the name and tyoe of institution in the space provided

Part B: Details of medical treatment/surgical operation

Please provide detailed description of envisaged medical treatment or surgical operation and reason(s) why the treatment or operation is required:-

_____

_____

_____

Part C: Motivation for seeking consent of the Minister

- Parent/guardian unreasonably refusing to give consent or to assist the child in giving consent

Motivation:

_____

_____

_____

- Parent/guardian incapable of giving consent or if assisting the child to give consent

Motivation:

_____

_____

_____

- Parent cannot readily be traced/ is deceased*
  Steps taken to trace parents

Motivation:

_____

_____

_____

* attach copy of parent's or guardian's death certificate

- Child unreasonably refusing to give consent

Motivation:

_____

_____

_____

Part D: Consent/ refusal of consent by Minister

I _____ (insert name) duly authorised, hereby give consent for the medical treatment to be given to/ surgical operation to be performed upon (delete whichever is not applicable) _____ (insert child's name)

I _____ (insert name) duly authorised, do not consent to the medical treatment/ the performance on the surgical operation applied for.

Tick whichever is applicable

_____

SIgnature

_____

Full name

_____

Designation

_____

Date

FORM 34

CONSENT TO SURGICAL OPERATION BY A CHILD

(Regulation 48)

[SECTION 129(3) OF THE CHILDREN'S ACT 38 OF 2005]

NB Child to be 12 years of age or older and of sufficient maturity and having the mental capacity to understand the benefits, risks and social implications of the surgical operation

Part A: Details concerning the child, the particulars of the person performing the surgical operation or institution where it is to be performed and the parent/guardian assisting the child

Full name of child	
Date of birth/ID number/passport number*	
Address of child	
Contact details	
Age of child (12 or older)	

Particulars of person/hospital/clinic/surgery/ other institution* performing the surgical operation

Name	
Practice no/hospital/clinic/surgery/ staff position	
Address	
Contact details	
Nature of surgical operation	
Details of other institution performing surgical operation	

*Please furnish details concerning the name and type of institution in the space provided

Particular of parent(s) or guardian(s) assenting to surgical operation

Parent/Guardian 1

Full name of parent/guardian	
Date of Birth/ID number/Passport no	
Address of parent	
Contact details	
Relationship to child	

Parent/Guardian 2

Full name of parent/guardian	
Date of Birth/ID number/Passport no	
Address of parent	
Contact details	
Relationship to child	

Part B: Explanation of nature, consequences, risks and benefits of surgical operation

I _____ (name of person seeking child's consent to perform a surgical operation) confirm that I have explained to _____ (name of child consenting to surgical operation) the following in a manner that is understandable to the child:-

- The nature of the problem requiring a surgical operation
- The most suitable surgical operation in my opinion
- Any risks associated with the surgical operation
- The benefits associated with surgical operation
- Any alternative form of treatment
- The social implications of the treatment or surgical operation (if any)
- Any other implications or possible consequences of the surgical operation (specify in space provided below)

_____

_____

I have given the child an opportunity to ask questions relating to the above.

I have satisfied myself that the child is 12 years or older and is of sufficient maturity and has the mental capacity to understand the risks, benefits, social and other implications of the surgical operation.

I have satisfied myself that_____ _____ (insert name of parent(s)/guardian(s)) has duly assisted the child to give consent to the surgical operation.

_____

Signature of person seeking consent to perform the surgical operation

_____

Name of person seeking consent to perform the surgical operation (write in full)

_____

Designation of person seeking consent to perform the surgical operation

_____

Date: _____

Part C: Consent of the child

I, _____ (insert child's name) understand that the following surgical operation is going to be performed on me:

_____

_____

_____

I,_____ (insert child's name) understand the risks and benefits and possible consequences of this surgical operation that have been explained to me, and I confirm that I have been given opportunity to ask questions about my condition, alternative forms of treatment, and the risks of non-treatment, and possible consequences of the surgical operation.

I believe that I have sufficient information to give my informed consent, and do so freely.

_____

Signature of child

_____

Name of child (write in full)

_____

Date

Part D: Declaration of the parent/guardian of child parent

I _____(insert name of parent(s) or guardian(s)) assisting the child to consent to a surgical operation confirm that the child is 12 years or older and is of sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications of the following surgical operation _____ (insert type of surgical operation) and that _____ (insert name of child) has been duly assisted by me to furnish consent.

_____

Siganture of parent(s)/guardian(s)

_____

Full name of parent or guardian

_____

Date

FORM 35

CONSENT TO SURGICAL OPERATION OF A CHILD BY A PARENT

(Regulation 49)

SECTION 129(3) OF THE CHILDEN'S ACT 38 OF 2005

Part A: Details concerning the child, the parent aged under 18 years of the child upon whom the surgical operation is to be performed, the parent(s) or guardian of the child parent aged below 18 years, and the particulars of the person performing the surgical operation or institution where it is to be performed.

Child upon whom surgical operation is to be performed

Full name of child	
Date of birth/ID number/passport no	
Address of child	
Contact details	
Age of child (12 or older)	

Parent aged below 18 years giving consent ("child parent")

Full name of child	
Date of birth/ID number/passport no	
Address of child	
Contact details	
Age of child	

Parent/Guardian assisting the child parent to give consent

Full name of child	
Date of birth/ID number/passport no	
Address of child	
Contact details	
Relationship to child parent	

Particulars of person/hospital/clinic/surgery/other institution* performing surgical operation

Full name of child	
Practice no/hospital/clinic/surgery/staff position	
Address of child	
Contact details	
Nature of surgical operation	
Details of other institution performing surgical operation*	

Part B: Explanation of nature, consequences, risks and benefits of surgical

I _____ (name of person seeking consent to perform a surgical operation) confirm that I have explained to _____ (name of child parent consenting to surgical operation) the following in a manner that is understandable to him/her:-

- The nature of the problem requiring a surgical operation
- The most suitable surgical operation in my opinion
- Any risks associated with the surgical operation
- The benefits associated with surgical operation
- Any alternative form of treatment
- The social implications of the treatment or surgical operation (if any)
- Any other implications or possible consequences of the surgical operation (specify in space provided below)

_____

_____

_____

I have given the child parents opportunity to ask questions relating to the above.

I have satisfied myself that the child parent is 12 years or older and is of sufficient maturity sand has the mental capacity to understand the risks,

benefits, social and other implications of the surgical operation upon _____(insert name of child on whom surgical operation is to be performed).

I have satisfied myself that_____ (insert name of parent(s)/guardian(s)) has duly assisted the child giving consent to the surgical operation

_____

Signature of person seeking consent to perform the surgical operation

_____

Name of person seeking consent to perform the surgical operation (write in full)

_____

Designation of person seeking consent to perform the surgical operation

Date: _____

Part C Consent of the child parent

I, _____ (insert name of child parent) understand that the following surgical operation is going to be performed (insert type of surgical operation): _____

_____(insert name of child upon whom surgical operation to be performed).

I understand the risks and benefits and possible consequences of the surgical operation that have been explained to me, and I confirm that I have been

given an opportunity to ask questions about the health condition of my child, alternative form for treatment, and the risks of non-treatment, and possible consequences of the surgical operation.

I believe that I have sufficient information to give my informed consent, and do so freely.

_____

Signature of child parent

Name of child parent (write in full) _____

Date _____

Part D Declaration of parent/guardian of child parent

I _____ (insert name of parent(s) or guardian(s) assisting the child parent to consent to a surgical operation) confirm that he/she is 12 years or older and is of sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications of the following surgical operation _____ (insert type of surgical operation), and that _____ (insert name of child) has been duly assisted by me to furnish consent.

_____

Signature of parent(s)/guardian(s)

Full name of parent or guardian _____

_____

Date





The Children's Act Guide for Health Professionals is written for people working in the health sector and outlines the specific provisions of the Children's Act that apply to health professionals.

The guide explains the children's rights and principles that inform the Children's Act and addresses difficult questions such as:

- How do you do determine the best interests of the child?
- Do you need to report consensual sex between adolescents?

The guide details the consent requirements for different health services; and explains what to do in an emergency, or in case of conflict between parents and the child. It informs health professionals of their mandatory obligations to report abuse and neglect and examines how to interpret these requirements in the light of recent court judgments.

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