CHILDREN'S RIGHT TO CONSENT TO MEDICAL TREATMENT AND A CONSIDERATION OF THE CHANGES EFFECTED IN THE CHILDREN'S BILL B70 D OF 2003

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A mini-thesis submitted in partial fulfillment of the requirements for the degree of Masters Legum in the Faculty of Law, University of the Western Cape.

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KEYWORDS

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ABSTRACT

Children's right to consent to medical treatment and a consideration of the changes effected in the Children's Bill B70 D of 2003.

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Children's right to consent to medical treatment and the balancing of parental rights have become the focus of much debate in South Africa over the last few decades. Issues concerning the age at which children can consent to medical treatment, either with or without parental consent, have become pertinent especially in light of the escalating HIV pandemic.

This thesis examines the law as it developed with particular regard to the age at which children can consent to medical treatment and have access to contraceptives. It will further examine the role that parents play when children exercise their right to consent to medical treatment and access to contraceptives. Several changes have taken place in domestic legislation and this thesis will analyse those changes with reference to the provisions on the protection of health rights of children.

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DECLARATION

I declare that "*Children's right to consent to medical treatment and a consideration of the changes effected in the Children's Bill B70 D of 2003*" is my own work, that it has not been submitted for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged by complete references.

Full name: Zarina Fakier Date: 15 May 2006

Signed ____________________________

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Chapter 1

This thesis deals with children's right to consent to medical treatment and a consideration of the changes effected in the Children's Bill B70 D of 2003.

This chapter will provide a synopsis of the pertinent issues relating to the requirements for obtaining the necessary consent for medical treatment. It is to be noted that this thesis will not engage in a comparative study, but will rather cover domestic developments as they unfolded over the period in which the HIV pandemic had swept across the globe and more particularly South Africa.

Chapter 2 will discuss the most significant articles of international law which are set out in the Convention on the Rights of the Child (CRC). The four key rights of the CRC will be discussed at length, namely the right to non-discrimination (article 2), the primacy of the best interests of the child (article 3), the right of the child to survival and development (article 6), and the right of the child to participate in decisions affecting him or her (article 12). Important provisions dealing with the child's right to health and health services (article 24) and the child's right to privacy (article 16) will also be discussed. Both the CRC and the African Charter on the Rights and Welfare of the Child (referred to as the Charter) do not contain any provisions relating to HIV/AIDS, because they were both formulated before the HIV pandemic spread so rapidly. However, the Committee on the Rights of the Child developed a number of General Comments that deal with issues not discussed in the CRC. General Comment No.3 focuses on important aspects of HIV/AIDS, and General Comment No.4 deals with adolescent health and development. Chapter 2 will further elaborate on the important articles in the Charter.

Chapter 3 will deal with consent issues that are pertinent to the field of medical treatment and the testing of children. It will elaborate on how the doctrine of informed consent developed under the common law. Chapter 3 will further focus on the relationship between the child's consent and parental consent and at what age children should have

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access to contraceptives. Chapter 3 will also look at a number of cases decided by our courts that deal with principles relating to informed consent.

Chapter 4 will focus on a number of other rights that are important for the protection of the health rights of children; in particular, the common law and constitutional protection of the rights to privacy, dignity and equality will be elaborated upon. This chapter will elaborate on the factors that led to the development of equality jurisprudence in South Africa.

Chapter 5 deals with Legislation and Law reform and will focus on education policies on HIV/AIDS with reference to the National Education Policy Act 27 of 1996 and the South African Schools Act 84 of 1996. The Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000 will be dealt with. The Child Care Act 74 of 1983 and its shortcomings will be highlighted. This chapter will highlight the recommendations and submissions prior to the passing of the Children's Bill B70 D of 2003 relating to the age of consent to medical treatment and access to contraceptives. Lastly, the changes that were made in the Children's Bill regarding the age of consent to medical treatment, access to contraceptives and other health issues will be dealt with.

Chapter 6 of the thesis draws attention to concluding remarks and recommendations concerning the above chapters.

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Chapter 2

An overview of the international law instruments: The Convention on the Rights of the Child and the African Charter on the Rights and Welfare of the Child

1. Introduction

This chapter will discuss the most significant international human rights instruments relating to children which form the normative framework for the consideration of children's rights. These are the United Nations Convention on the Rights of the Child[1] (hereafter referred to as the CRC) and the African Charter on the Rights and Welfare of the Child (hereafter referred to as the Charter).[2]

Two of the most important legally binding instruments namely, the CRC and the Charter are of particular significance in determining the rights of the child. The CRC is the most comprehensive document containing all the basic rights of the child, and was adopted by the United Nations General Assembly in 1989. South Africa ratified the CRC on 16 June 1995, a day which is very significant as it is now celebrated annually as a South African holiday, Youth Day. The Charter, however, is a very important regional human rights instrument dealing with specific issues relevant to children in Africa.[3] Some of the key issues which were not discussed in the CRC were included in the Charter.[4]

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[1] This Convention was adopted, signed and ratified by the General Assembly on 20 November 1989, and came into force on 2 September 1990.

[2] This Charter was adopted by the Organisation of African Unity (now the African Union) on 11 July 1990 and came into force on 29 November 1999.

[3] Viljoen F, *The African Charter on the Rights and Welfare of the Child*, Chapter 12, *Introduction to Child Law in South Africa*, Davel CJ (ed), First edition, 2000, p218.

[4] Examples of some issues that were not dealt with are the circumstances of children living in the apartheid era. Socio-economic factors such as illiteracy and low levels of sanitation, which threaten the right to survival, were also ignored. The CRC also did not consider the importance of family in the upbringing of the child. Viljoen F, *The African Charter on the Rights and Welfare of the Child*, op cit, p 218.

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Child[5] developed several General Comments which are used as a guide by States Parties that deal with matters that are not covered in the CRC.[6] General Comment No.3[7] addresses important issues around HIV/AIDS and the rights of the child as well as the implementation of measures and strategies to fight the spread of AIDS. General Comment No.4[8] deals with adolescent health and development in the context of the CRC. It is interesting to note that 'adolescence' is not specifically regarded as a sub-group of 'children'. This oversight to recognize the specific needs of adolescents is reflected in the scant attention paid by States Parties to important issues relating to adolescents. General Comment No.4 therefore addresses this oversight by concentrating on health issues pertaining to adolescents.[9] These General Comments are extremely important because they raise awareness and provide States Parties with guidance and support in their efforts to guarantee the respect for, protection and fulfilment of, the rights of adolescents and children.[10] Although the General Comments do not have binding force and cannot be ratified (as opposed to the provisions of the CRC), they are indeed persuasive and often contain valuable discussions that can be used to interpret States duties under international law. General Comment No.5[11] outlines States Parties' obligations to develop general measures of implementation of the CRC. These measures refer to specific provisions of the CRC and also rely on the ratification of other key international human rights instruments that relate to the rights of the child.[12]

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[5] For further information on the duties of the Committee on the Rights of the Child, see *infra,* 2.1.3 Significance of the CRC, p9.
[6] Wyndham J, The Diplomacy Training Program in Co-operation with the Pacific Concerns Resource Centre & Save The Children, Children's Rights Training , Suva, Fiji, November 6-13, 2004, p6. http://www.dtp.unsw.edu.au/Childrens_Rights_Training_2003_Background_Paper.htm Date accessed 27 September 2005.
[7] General Comment No.3, "HIV/AIDS and the right of the child", CRC/GC/2003/3, 17 March 2003.
[8] General Comment No.4, "Adolescent health and development in the context of the Convention on the Rights of the Child", CRC/GC/2003/4, 1 July 2003.
[9] Wyndham J, The Diplomacy Training Program, op cit, p7.
[10] General Comment No 4, op cit, para3, p2.
[11] General Comment No.5, "General measures of implementation of the Convention on the Rights of the Child", CRC/GC/2003/5, 3 October 2003. www.unhchr.ch/tbs/doc.nsf/(symbol)/CRC.GC.2003.5 Date accessed 25 March 2005.
[12] Wyndham J, The Diplomacy Training Program, op cit, p7.

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The Committee on the Rights of the Child, the body monitoring the CRC, constantly stresses the need for a rights-based-approach to implementation.[13] The general principles of the CRC as laid down in articles 2, 3, 6 and 12 should be applied and duly integrated into the implementation of all articles of the CRC. These rights are central to the development of children who have a say in deciding what is in their best interests. Furthermore, these rights enable children to gradually take responsibility for different areas of their own lives. They also further recognize that, as children evolve, they can exercise more rights and should rightfully be regarded as evolving, autonomous individuals.[14] These rights are important when we analyze children's rights to make important medical decisions regarding health-care.[15]

At the outset, it is relevant to refer to the definition of a child. The CRC defines a child as every human being below the age of 18 years, unless under the law applicable to the child, majority is attained earlier.[16] The definition of a child is more comprehensive in the Charter[17] and provides for a more stringent, clear and concise meaning. The Charter is applicable to every human being under the age of eighteen, there are no limitations or attached conditions. This provision does not strictly reflect African culture and tradition, as the African context of childhood is not perceived and conceptualized by chronological

[13] The UNAIDS and OHCHR *HIV/AIDS and Human Rights- International Guidelines* offers guidance to move from a policy-based approach to a rights-based approach. HIV/AIDS and human rights in SADC. (Mozambique) The country report on HIV/AIDS and human rights in Mozambique is the result of a one-year joint project between the Centre for the Study of AIDS and the Centre for Human Rights, both based at the University of Pretoria. This Project was inspired by the need to develop a rights-based approach that guarantees basic human rights to all people living with or affected by HIV/AIDS in the region. (The study was guided by the document *HIV/AIDS and Human Rights-International Guidelines* 1 of 1996, adopted by UNAIDS and the office of the United Nations High Commissioner for Human Rights). The aim of the research report, within the *SADC HIV/AIDS framework for 2000-2004* is to assist decision-makers to make informed policy choices for individual SADC countries. Legislators, the judiciary, members of NGO's (non-governmental organizations) and people living with or affected by HIV/AIDS all need to be informed about those human rights in the context of HIV/AIDS that are already protected within their countries. Finally, they should be able to identify areas where there is a gap and need to lobby for change, and to initiate change in an effort to move towards a rights-based approach. www.ohchr.org Date accessed 9 February 2006.

[14] Van Bueren G, *The United Nations Convention on the Rights of the Child: An Evolutionary Revolution*, Chapter11 in *Introduction to Child Law in South Africa* by Davel CJ (Ed), First edition 2000, p 205.

[15] These rights will be discussed in Chapter 3 and Chapter 4 of this thesis.

[16] Hodgkin R, Newell P, *Implementation Handbook for the Convention on the Rights of the Child* (UNICEF), Fully revised edition, June 2002, p 1.

[17] Article 2 of the African Charter on the Rights and Welfare of the Child, OAU Doc. CAB/LEG/24.9/49 (1990).

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age. Childhood, in the African context, is usually defined in terms of intergenerational obligations of support and reciprocity.[18]

The Committee on the Rights of the Child, consisting of experts of high moral standing and recognized competence, deals with matters relating to children's rights.[19] The Committee considers reports by States that have ratified the Convention.[20] These States should report to the Committee on the steps they have taken to give effect to all the rights contained in the CRC.[21] The initial report is due within two years of ratification, and thereafter a progress report must be given to the Committee every five years. The reports, which should be made widely known to the public, must provide the Committee with adequate information on how the CRC is being implemented domestically.

2.1.1 Status of the CRC

South Africa as a ratifying country is obliged to enforce and give effect to the obligations contained in international human rights instruments. Governments are accountable at an international level to "enforce and honour their treaty obligations at domestic level."[22] A ratifying State Party is further obliged to review its legislation to ensure that domestic law is consistent with the provisions of the treaty. [23]

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[18] Lloyd A, *Regional Developments on the Rights and Welfare of Children in Africa: A General Report on the African Charter on the Rights and Welfare of the Child and the African Committee of Experts*. http://www.uwe.ac.uk/law/research/acr/report.htm p1, Date accessed 19 April 2005

[19] Van Bueren G, The *United Nations Convention on the Rights of the Child: An Evolutionary Revolution*, op cit, p210.

[20] Ibid, p211.

[21] Article 44 of the CRC, G.A. res. 44/25, annex, 44 U.N. GAOR Supp. (No. 49) at 167, U.N. Doc. A/44/49 (1989)

[22] Van Bueren G, *The United Nations Convention on the Rights of the Child: An Evolutionary Revolution*, op cit, p199.

[23] Sloth-Nielsen J, *The Role of International Law in Juvenile Justice Reform in South Africa*, LLD dissertation, unpublished, UWC, 2001, p36

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2.1.2 Nature of State obligations

All States that have ratified the CRC have an obligation to ensure that the provisions of the CRC are respected and implemented. The obligation placed on States to enforce the provisions of the CRC is expressly laid down in Article 4 which provides that:

> "States Parties shall undertake all appropriate legislative, administrative, and other measures for the implementation of the rights recognized in the present Convention. With regard to economic, social and cultural rights, States Parties shall undertake such measures to the maximum extent of their available resources and, where needed, within the framework of international co-operation."

It is confirmed in General Comment No.5[24] that when a State ratifies the CRC, it takes on obligations under international law to implement it. Implementation is the process whereby States Parties take action to ensure the realization of all rights in the CRC for all children in their jurisdiction. While it is the State which takes on obligations under the CRC, its task of implementation - of making reality of the human rights of children - needs to engage all sectors of society and children themselves. Ensuring that all domestic legislation is fully compatible with the Convention and that the Convention's principles and provisions can be directly applied and appropriately enforced is fundamental.[25] Furthermore, the Committee on the Rights of the Child has identified a wide range of measures that are needed for effective implementation, including the development of special structures and monitoring, training and other activities in Government, parliament and the judiciary at all levels.[26]

The General Comment confirms the distinction between civil and political rights on the one hand, and economic, social and cultural rights on the other hand. With regard to economic, social and cultural rights, States Parties must undertake such measures to the

[24] General Comment No.5, op cit, p1.

[25] General Comment No.5, op cit, para 1, pp 1-2.

[26] In 1999, the Committee on the Rights of the Child held a two-day workshop to commemorate the tenth anniversary of adoption of the CRC by the United Nations General Assembly. The workshop focused on general measures of implementation following which the Committee adopted detailed conclusions and recommendations.

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maximum extent of their available resources and, where needed, within the framework of international co-operation.[27] This indicates a realistic acceptance that lack of resources, whether financial or otherwise, can hamper the full implementation of economic, social and cultural rights in some States. There has to be "progressive realization" of such rights which can be implemented only subject to the availability of resources.[28]

The Committee emphasizes that in the context of the CRC, States must see their role as fulfilling clear legal obligations to each and every child. Implementation of the human rights of children must not be seen as a charitable process which bestows favours on children.[29]

The Convention places new obligations on States as far as the protection of children is concerned. States are obliged to take effective measures to abolish traditional practices that are prejudicial to the health of children. A very important obligation of States is to ensure that they do not discriminate against children in their enjoyment of the CRC's rights.[30] States Parties must refer to the requirements of article 2 of the CRC which places them under an obligation to "respect and ensure" the rights in the CRC to each child.

2.1.3 Significance of the CRC

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The CRC creates new rights under international law where no such rights existed.[31] The CRC further creates binding standards in areas which, until the Convention's entry into force, were only regarded as non-binding recommendations.[32] The CRC also imposes new obligations on the State to protect children.

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[27] General Comment No.5, op cit, para 6, p2.
[28] General Comment No.5, op cit, para 7, p3.
[29] General Comment No.5, op cit, para 11, p3.
[30] Van Bueren G, *The United Nations Convention on the Rights of the Child: An Evolutionary Revolution,* op cit, p 203.
[31] Van Bueren G, *The United Nations Convention on the Rights of the Child: An Evolutionary Revolution,* op cit, p 203.
[32] Ibid, p203.

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There are two new principles of interpretation in international law that underpin the CRC viz: (1) the best interests of the child shall be a primary consideration when dealing with all matters affecting children.[33] (2) the evolving capacities of the child should be considered to enable children gradually to take responsibility for different aspects of their lives. [34]

2.2 General principles

In essence, the four key rights of the CRC form the pillars of the Convention and form the backbone of the children's rights philosophy. The identification of these four general principle, chosen by the Committee on the Rights of the Child, highlights to all the States the fundamental values underlying the Convention, of ensuring "a common philosophical approach to the broad spectrum of areas addressed by the Convention", and of "defining decisive criteria" to assess and establish the progress made in implementing a children's rights approach.[35] These four key rights are[36]:

(1) the prohibition against discrimination (article 2),

(2) the primacy of the best interests of the child (article 3);

(3) the right of the child to survival and development (article 6);

(4) the right of the child to participate in decisions affecting him or her (article 12)

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This next section will focus primarily on these rights. The CRC is primarily concerned with the four "P's", namely the participation of children in decisions affecting their own destiny and their participation in community life; the protection of children against discrimination and all forms of torture; the prevention of harm to children, the development of preventative health-care and the prevention of child abduction; the provision of assistance to ensure that children's basic needs are met.[37]

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[33] Article 2.

[34] Van Bueren G, *The United Nations Convention on the Rights of the Child: An Evolutionary Revolution,* op cit, pp 204-5; Article 5 and article 12; Refer to page 18 for a discussion on article 12.

[35] Nowak M, Convention on the Rights of the Child, *Article 6, The Right to Life, Survival and Development,* Martinus Nijhoff Publishers, 2005, p17.

[36] Van Bueren G, The *United Nations Convention on the Rights of the Child: An Evolutionary Revolution,* op cit, p203.

[37] Ibid, p 203.

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2.2.1 The right to non-discrimination (Article 2)

Article 2 is a very broad clause that not only prohibits discrimination against children on the basis of a child's status but also prohibits discrimination on the basis of the family's status. Article 2 obliges States to respect and ensure the right set forth in the Convention to each child within their jurisdiction without discrimination of any kind. This non-discrimination obligation requires States to identify individual children and groups of children whose rights may demand special measures for realization and recognition. The Committee highlights, in particular, the need for data collection to be disaggregated to enable discrimination or potential discrimination to be identified.[38] Addressing discrimination may require changes in legislation, administration and resource allocation, as well as educational measures to change attitudes. Discrimination against children occurs not only between adults and children, but also between different groups of children. In South Africa, discrimination between rural and urban children surfaces frequently. Children living in rural communities have less access to educational and health care facilities than children living in urban areas.[39] This may be particularly prejudicial to children and orphans infected and affected by HIV/AIDS and related illnesses. Discrimination should also not occur in schools. No learner, student or educator with HIV/AIDS may be unfairly discriminated against, either directly or indirectly.[40] One can say that children living on the margins of urban life are discriminated against in the enjoyment of many of their economic and social rights.[41]

Paragraph 2 of article 2 of the CRC emphasizes the need to protect children from all forms of discrimination on the basis of the status or activities of their parents and others close to them.[42]Article 2 emphasizes that all the rights in the CRC must apply to all

[38] General Comment No.5, op cit, para 12, p4

[39] Wolf J, The concept of the "Best Interests" in terms of the UN Convention on the Rights of the Child in Freeman M and Veerman P, in *The Ideologies of Children's Rights* (1992).

[40] Van Bueren G, *The United Nations Convention on the Right of the Child: An Evolutionary Revolution*, op cit, p 208.

[41] General Comment No.3. HIV/AIDS and the Rights of the Child. p4.

[42] Hodgkin R, Newell P, *Implementation Handbook for the Convention on the Rights of the Child,* op cit, p20.

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children in the State including visitors, refugees and those illegally in the State. Alien children are therefore also accorded equal rights in terms of the CRC. Health care and education (article 28 of the CRC) should be provided to children as a matter of principle according to the letter and the spirit of articles 2 and 3 of the CRC.[43]

Discrimination increases the vulnerability of children with HIV/AIDS.[44] Children and youth infected with and affected by HIV/AIDS should have equal access to the rights and protection afforded by our law, and should be protected from being unfairly discriminated against on the basis of their HIV status. Children orphaned by the epidemic experience stigma and discrimination and are very often more vulnerable to exploitation and abuse. Orphans, too, may have multiple needs which include physical, material, intellectual and psycho-social needs, and unless the state addresses these needs, these children will become prime targets of exploitation, not only sexual exploitation but also stigmatization by the communities that they live in. Discrimination also exacerbates the epidemic because children in rural areas have less accessibility to health care services, which makes them more vulnerable to infection. These children are therefore doubly victimized.[45] These discriminatory practices are violations of children's rights under article 2 of the CRC. Laws and policies should be enacted to address all forms of discrimination that increase the impact of the AIDS epidemic.[46]

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2.2.2 Best interests of the child (Article 3)

The term "best interests of the child" is fairly widely used in everyday language. But what does the term actually mean? Barratt states that the phrase is not clear and the principle has been described as "vague, indeterminate, or overly susceptible to biased interpretation by decision-makers".[47] However, the CRC is quite explicit that all actions

[43] Hodgkin R, Newell P, *Implementation Handbook for the Convention on the Rights of the Child*, op cit, p26.
[44] A detailed discussion on stigma and discrimination will follow in the ensuing chapter.
[45] General Comment No.3, op cit, para 5-6, p3.
[46] General Comment No.3, op cit, para 7, p3.
[47] Barratt A, "*The best interest of the child, Where is the child's voice*?", in *The Fate of the child: Legal Decisions on Children in the New South Africa,* Chapter 7, Burman S (ed), First edition 2003 (Juta Law), p145.

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concerning children should take full account of their best interests, as it is laid down in Article 3 which provides that:

> (1) In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, authoritative or legislative bodies, the best interests of the child shall be a primary consideration.

The Committee has highlighted, with respect to article 3(1), that the best interests of the child shall be a primary consideration in all actions concerning children, as one of the general principles of the CRC, alongside articles 2, 6 and 12. Article 3(1) emphasizes that governments and other public and private institutions must ascertain the impact of their actions on children to guarantee that the best interests of the child are a primary consideration.

Article 3(1) refers to actions undertaken by "public or private social welfare institutions, courts of law, administrative authorities or legislative bodies". These bodies should apply the best interests principle by systematically considering how children's rights and interests are or will be affected by their decisions and actions, for example, by a proposed or existing law or policy or court decision, including those which are not directly concerned with children, but which indirectly concern children. The scope of the principle is very wide, as it goes beyond State-initiated actions and also covers private bodies.[48] The Committee has emphasized that consideration of the best interests of the child should be incorporated into national plans and policies for children including at parliamentary level when budgeting and allocation of resources are considered.[49]

There is an interrelationship between the general principles viz. articles 2, 3, 6 and 12. Thus, the principles of non-discrimination, maximum survival and development, and respect for the views of the child are relevant to determine what the best interests of the

[48] Hodgkin R, Newell P, *Implementation Handbook for the Convention on the Rights of the Child*, op cit, p 42.
[49] Ibid, p42.

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child are, either in a particular situation or in a group.[50] When one interprets the best interests of the child, it must be consistent with the spirit of the entire CRC, with special emphasis on firstly, the child as an individual with his or her own views and feelings and secondly, the child as the beneficiary of social and economic rights.[51]

The principle of best interests of a child is very important because it clearly links those interests with respect for, and fulfilment of, the other important rights related to privacy, dignity and autonomy.[52] There are often competing or conflicting human rights interests, for example, between individual children, between different groups of children or even between children and adults. What may be in the best interests of the parent may not always necessarily be in the best interests of the child, especially as far as children's consent to medical treatment and access to contraceptives are concerned.

In conclusion, the best interests of the child can best be summed up as a principle of interpretation that must be considered in relation to all the rights in the CRC, and to all actions taken concerning children. The list of factors that could be considered is never ending, and depends on the circumstances of each case, but should include the opinions and viewpoints of the child himself or herself.

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2.2.2.1 Role of Parents

One of the most fundamental provisions of the CRC is that children are best raised and cared for in a family environment.[53] The CRC promotes the family's role in making sure children's rights are fulfilled via articles 5[54] and 18.[55]

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[50] *The Governing Body of Mikro v The Western Cape Minister of Education* [2005] 2 All SA 37 (C); *Fletcher v Fletcher* 1948 (1) SA 130 (A); *Minister for Welfare and Population Development v Fitzpatrick and Others* [2000] 7 BCLR 713 (CC); *Fraser v Naude and Others* [1998] 11 BCLR 1357 (CC).

[51] Hodgkin R , Newell P, *Implementation Handbook for the Convention on the Rights of the Child*, op cit, pp42-43; *Grootboom v Oostenberg Municipality* [2000] 3 BCLR 277 (C); *Government of the Republic of South Africa and Others v Grootboom and Others* 2000 (11) BCLR 1169 (CC).

[52] Understanding the Psychosocial Needs of Refugee Children and Adolescents, The Convention on the Rights of the Child, p1.
http://earlybird.qeh.ox.ac.uk/rfgexp/rsp_tre/ing_sh/head_d4.gif Date accessed 29 September 2005.

[53] Sloth-Nielsen J, *Realising the rights of children growing up in child-headed households. A guide to laws, policies and social advocacy*, Community Law Centre, UWC, 2004, p5.

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The concept that it is best for children to grow up within their family is supported by the principle that, wherever possible, children should not be separated from their family.[56] Article 20 further states that children who are deprived of their families temporarily or permanently are entitled to special protection and assistance from the State.

However, the right to parental care is perhaps the right which is affected most directly by HIV/AIDS. Thousands of children will not be able to be cared for by their biological parents due to AIDS. Parents are dying at a younger age as a result and children are orphaned at very tender ages. In many households, there are many cases where one or both parents might be incapacitated or be without jobs, resulting in less food and other essential resources available to children infected with or affected by HIV/AIDS. Even the extended family system is already under immense strain due to the sheer numbers of children already becoming orphaned by AIDS.[57] It is the responsibility of the State to take all appropriate measures to ensure that children receive care, preferably care within the family, rather than institutional care.[58] It is imperative that models of care which are able to support AIDS orphans are developed, supported and sustained by the State.[59]

Our courts have had to decide a number of cases involving children in order to determine what the best interests of the child relating to parental care, means. In *Bannatyne v*

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[54] Article 5 provides that States Parties shall respect the responsibilities, rights and duties of parents or, where applicable, the members of the extended family or community as provided for by local custom, legal guardians or other persons legally responsible for the child, to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognised in the present Convention. See page 14 for footnote 54.

[55] Article 18 provides that States Parties shall use their best efforts to ensure recognition of the principle that both parents have common responsibilities for the up- bringing and development of the child. Parents, or, as the case may be, legal guardians, have the primary responsibility for the upbringing and development of the child. The best interests of the child will be their basic concern. (2) For the purpose of guaranteeing and promoting the rights set forth in the present Convention, States Parties shall render appropriate assistance to parents and legal guardians in the performance of their child-rearing responsibilities and shall ensure the development of institutions, facilities and services for the care of children. See page 14 for footnote 55.

[56] Support for this principle is also found in Article 9.

[57] Barrett K, *The Rights of Children: Raising the Orphan Generation* , Lawyers for Human Rights: HIV/AIDS and Human Rights Programme, p4. http://www.cindi.org.za/papers/paper11.htm Date accessed on 23 March 2005.

[58] Article 18(2) of the CRC

[59] Article 20 of the CRC.

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Bannatyne,[60] the Constitutional Court held that the best interests requirement places an obligation on parents to properly care for their children.[61] The best interests of children are often determined by looking at the relationship between the rights of children, their parents and other family members.[62] Children rely on family members for provision of basic necessities, affection and "socialisation into adulthood",[63] and to grow up in caring family settings. On the other hand, children who are left in the care of other family members are frequently exposed to child abuse, rape, domestic violence and neglect, which are obviously not in the child's best interests. It is my submission that in a number of instances, working parents are forced to leave their children in the care of neighbours, because family members are either ill, or there are no extended family members to care for their children. However, the best interests of the child should be taken into account as a paramount consideration in all matters affecting children.

2.2.3 The child's right to life and maximum survival and development (Article 6)

Children's survival rights are of primary importance. They include much more than the rights necessary for basic survival. States must take positive steps to ensure that children enjoy a full life, with the potential for maturing into healthy adults.[64] Article 3 of the Universal Declaration of Human Rights[65] upholds the right to life as a universal human rights principle: "Everyone has the right to life, liberty and security of person". Article 6 of the International Covenant on Civil and Political Rights[66] (hereafter the ICCPR) upholds the same principle: "Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life." It is not enough for article 6 to protect children's rights to life. Children must be provided with the

[60] 2003 (2) SA 363 (CC), p 24.
[61] Currie I, De Waal J, *Children,* Chapter 27, *The Bill of Rights Handbook,* Fifth edition, 2005, p619. The State should however provide the required legal and administrative infrastructure to ensure that children receive the protection they are entitled to in terms of section 28 of the Constitution (Act 108 of 1996.) For a full discussion on section 28 see chapter 3 *infra.*
[62] Currie I, De Waal J, *Children,* Chapter 27, *The Bill of Rights Handbook,* op cit, p 619.
[63] Ibid, p620.
[64] Fortin J, *Children's Rights and the Developing Law,* Chapter Two in *International Children's Rights,* Second edition, Lexis Nexis Butterworth, 2003, pp38-39.
[65] Resolution 217 A (111) of the United Nations General Assembly, adopted on 10 December 1948.
[66] The ICCPR was adopted by the UN General Assembly on 16 December 1966 and entered into force on 23 May 1976.

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resources to develop their full potential.[67] In terms of article 6, the State is obliged to ensure that the child enjoys the right to survival and development by, for example, taking positive steps to prolong the life of the child, including taking steps to reduce infant mortality.

The text of article 6 of the CRC reads as follows:

(1) States Parties recognize that every child has the inherent right to life.

(2) States Parties shall ensure to the maximum extent possible the survival and development of the child.

The Committee expects States to interpret "development" in its broadest sense as a holistic concept, embracing the child's physical, mental, spiritual, moral, psychological and social development.[68] Implementation measures should be aimed at achieving the optimal development for all children.[69] The Human Rights Committee (hereafter the HRC)[70] regards the right to life as the supreme human right, because, without guarantee of this right, all other human rights will be meaningless.[71] The HRC notes that the right to life is very often too narrowly interpreted and that States should take all positive measures to reduce infant mortality, to increase life expectancy, and to eliminate malnutrition and epidemics. [72]

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The concept of development not only concerns the preparation of the child for adulthood, but also providing optimal conditions for childhood, for the child's life now. The right to survival includes steps that a State should take to ensure the healthy development of children, but this right to health should not be protected in isolation. The notion of survival and best possible development of the child is also linked to the right to life, and

[67] Article 6(2).
[68] Nowak M, Convention on the Rights of the Child, *Article 6, The Right to Life, Survival and Development,* op cit, p16.
[69] General Comment No.5, op cit, para 12, p4.
[70] The Human Rights Committee (HRC) is the body of independent experts that monitors implementation of the International Covenant on Civil and Political Rights by its State Parties.
[71] Nowak M, Convention on the Rights of the Child, *Article 6, The Right to Life, Survival and Development,* op cit, p14.
[72] In General Comment No 6, 1982, HRI/GEN/I/Rev.5.

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is of particular importance to the implementation of other rights in the CRC such as the rights to health, food and education.

Malnutrition, poverty and overcrowding also impact negatively on the survival and development of children. The right to development is "the right of individuals, groups and arguably, peoples to participate in, contribute to and enjoy continuous economic, social, political and cultural development in an environment in which all human rights can be realized."[73]

In conclusion, both the right of a child to enjoy the highest attainable standard of health and the right to enjoy nutritious food, clean drinking water and an adequate standard of living, should be included or subsumed under the state's duty to ensure to the maximum extent possible the survival and development of the child.[74] The Committee sees child development as a holistic concept, and stresses the key role played by parents and the family towards child development and the State's obligation to support them in this duty. In view of the above, a healthy child develops into a healthy adult who will be able to expose his or her full potential. Therefore, it becomes all the more important to curb the HIV pandemic in children and to give medical treatment to children so that they too are given the opportunity of living life to its full potential.

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2.2.4 The right of the child to participate in decisions affecting him or her (Article 12)

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The text of Article 12 reads as follows:

(1) States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.

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[73] Van Bueren G, *The United Nations Convention on the Rights of the Child: An Evolutionary Revolution,* op cit, p208.
[74] Article 6.

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(2) For this purpose, the child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law.

Article 12 is often singled out as being one of the most important in the CRC. It assures to children capable of forming their own views, "the right to express those views freely in all matters affecting them, the views of the child being given due weight in accordance with the age and maturity of the child".[75] The CRC also recognizes that in order to form and express their own views, children need access to information from a variety of sources.[76] What is more fundamental is that they are entitled to respect and dignity as they mature to adulthood. States must secure their rights to freedom of thought, privacy and a freedom to meet and mix with others and share their views. However, children cannot develop their views and critical thought without a right to education, which is recognized by providing for adequate schooling and formal education (article 28 of the CRC).[77]

Parents or guardians make decisions on behalf of the children which are in some cases not in their best interests. General Comment No.5[78] affirms that article 12 highlights the role of the child as an active participant in the promotion, protection and monitoring of his or her rights, and that it applies equally to all measures adopted by States to implement the CRC. Article 12 is regarded as a general principle of fundamental importance relevant to all aspects of implementation of the CRC and to the interpretation of all other articles.

The Committee on the Rights of the Child has consistently stressed that the child must be regarded as an active subject of rights and that a key purpose of the CRC is to emphasize

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[75] Article 12(1).

[76] Article 17 of the CRC which states that States must ensure that children have access to information and material from a diversity of national and international sources, especially those aimed at the promotion of their social, spiritual and moral well-being and physical and mental health.

[77] Fortin J, *Children's Rights and the Developing Law*, op cit, p41.

[78] General Comment No.5, op cit, para 12, p4.

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that human rights extended to children. The need to respect the child's developing capacity for decision-making is emphasized by references to the "evolving capacities" of the child.[79] There are various other articles in the CRC that include references to children's participation.[80]

In conclusion, Article 12 requires that children's rights to express their views and to give them their due consideration is implemented in relation to health and health services. Children should participate in the overall planning, delivery and monitoring of health services relevant to the child, and the child must have the right to consent to treatment or refuse consent to treatment, and must be able to make decisions for themselves if they have sufficient maturity to do so. This approach is in line with the evolving capacities of the child.[81] In cases involving infants and toddlers, the parents or guardians consent on their behalf in the case of medical treatment.[82]

The right of children to participate is a key instrument to meet all the other children's rights in South Africa.[83] When children actively participate in decisions and programs that affect them, they optimally express what their needs are and how those needs can be met.[84] In the context of poverty and HIV, child participation is vital, as it enables policy makers to be in touch with children's realities, and how they can best be protected and motivated in the context of vulnerability.[85]

Each person has a fundamental right to bodily integrity and individual autonomy and permission must therefore be sought before any medical process is carried out. A

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[79] Article 5.

[80] Article 9(2) refers to the child's right to be heard in relation to proceedings involving separation from his or her parents.

[81] The concept of evolving capacities of the child is interpreted according to the general principle in article 12, namely that the views of the child must be respected and given due weight in accordance with the age and maturity of the child.

[82] Consent will be fully discussed in Chapter 3 *infra.*

[83] Mniki N, *Heroes in the context of vulnerability: The participation of children in the Children's Bill,* in South African *Child Gauge,* 2005, Children's Institute, University of Cape Town, edited by Jacobs M, Shung-King M, Smith C, p43.

[84] Ibid, p43.

[85] When the Children's Bill B70D of 2003 was considered by Parliament, both adults who work in the children's sector and children living in the context of vulnerability were involved in the deliberations.

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violation of the right of informed consent is also a violation of a person's fundamental human right.[86]

2.3 Other relevant provisions

The four pillars of the Convention, discussed above, must be guided by principles that are relevant to all matters concerning children.[87] These matters would entail prevention and treatment of illnesses as well as care and support in the management of these illnesses.[88] HIV/AIDS affects many other rights including the right to an adequate standard of living; the right to privacy; the right to health; the right to social security. Medical treatment often involves an invasion of bodily and personal privacy. International human rights law recognises that, in the same way as adults have a right to self-determination, so children and adolescents too have the right to make choices concerning their bodies and treatment related to their bodies.[89] The next section will focus on the right to health and the right to privacy.

2.3.1 The right to health (Article 24)

The child's right to health and health services is governed by article 24 of the CRC which states that:

> (1) States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.

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[86] Informed consent will be discussed in detail in Chapter 3 *infra*.

[87] Collins T, Pearson L, *What does the "best interests of the child" mean?* April 2002, p1. www.sen.parl.gc.ca/lpearson Date accessed 19 April 2005.

[88] Sloth-Nielsen J, *Realising the rights of children growing up in child-headed households. A guide to laws, policies and social advocacy*, op cit, p6.

[89] Fortin J, *Parents' decisions and Children's health rights,* Chapter Ten, *Children's Rights and the Developing Law, International Journal of Law, Policy and the Family*, Second edition, Lexis Nexis Butterworths, 2003, p307.

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(2) States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:

a) to diminish infant and child mortality
b) to ensure the provision of necessary medical assistance and health care to all children with the emphasis on the development of primary health care.

Article 24 is an extension of the right to life and to survival and development to the maximum extent possible as set out in article 6 of the CRC. The principle of non-discrimination (article 2) requires States to recognize the rights of all children without discrimination to "the highest attainable standard of health" as well as to "facilities for the treatment of illness and rehabilitation of health." States Parties must ensure that no child is deprived of his or her right of access to health care services.[90] The State is obliged to provide the necessary medical assistance and health care to all children, especially primary health care both in urban and rural areas.[91]

Article 24 is most directly linked to the right to life and defines some of the most important State obligations deriving from the right of children to survival and development.[92] The promotion of adolescent health is vitally important to foster life skills and to promote the positive potential of young people. A healthy child inevitably will develop into a healthy adult and this can best be addressed by reducing the infant mortality rate and the rapid spread of the HIV/AIDS pandemic.

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2.3.2 The child's right to privacy (Article 16)

The text of the article 16 of the CRC concerns privacy and reads as follows:

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[90] Nowak M, Convention on the Rights of the Child, *Article 6, The Right to Life, Survival and Development,* op cit, p41.
[91] Hodgkin R, Newell P, *Implementation Handbook for the Convention on the Rights on the Child*, op cit, p 334.
[92] Nowak M, Convention on the Rights of the Child, *Article 6, The Right to Life, Survival and Development,* op cit, p41.

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1) No child shall be subjected to arbitrary or unlawful interference with his or her privacy, family, home or correspondence, or to unlawful attacks on his or her honour and reputation.
2) The child has the right to the protection of the law against such interference or attacks.

The most important invasions of the right to privacy of children occur in the context of informed consent to testing or treatment for HIV/AIDS. In addition, a person's HIV status should be protected in the case of unlawful disclosure.[93] The CRC and the Charter do not deal specifically with consent in the context of HIV/AIDS testing and treatment.[94] Article 16 affords the child a fundamental civil right that was established for everyone in the Universal Declaration of Human Rights[95] and the ICCPR.[96] In essence, Article 16 must apply to all children without discrimination. The child's privacy should be protected in all situations, whether it is in the family, in alternative care and in all institutions, facilities and services. In addition, Article 16 protects the child's family and home from arbitrary or unlawful interference. At the same time, the article raises issues concerning the environment in which the child lives, the privacy of his or her relationships and communications with others, which would include the right to confidential advice and counselling and control of access to information stored about the child in records or files.[97] It goes without saying that children's rights to privacy within the family would vary according to family structures, living conditions and socio-economic factors determining the private space available to the child. Furthermore, children's right to privacy should be protected by giving children a say in all decisions affecting their lives. Children's rights to privacy become important in cases of consent to

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[93] Although the common law and the Constitution protect the right to privacy, unlawful disclosures do take place in the workplace where there are inadequate mechanisms available to enable employees to disclose their HIV status safely. Draft Paper on HIV/AIDS Status, Department of Health, 2000, p51. http://www.doj.gov.za Date accessed 21 November 2005.

[94] The Children's Bill B70D of 2003, which was passed by the National Assembly on 14 December 2005, deals extensively with consent to medical treatment and surgical operations (section 129), HIV testing (section 130), counselling before and after HIV testing (section 132) and confidentiality of information on the HIV/AIDS status of children (section 133). This will be discussed in the last chapter below.

[95] 1948.

[96] See footnote 66.

[97] Hodgkin R, Newell P, *Implementation Handbook for the Convention on the Rights of the Child*, op cit, p213.

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HIV/AIDS testing and treatment, and their bodily integrity, dignity and human rights should be respected in this regard. The right to privacy is the cornerstone to the protection of autonomy and self-determination rights.[98]

2.4 General Comment No. 3. "HIV/AIDS and the Rights of the Child."

One of the main objectives which General Comment No.3 promotes is the realization of human rights of children in the context of HIV/AIDS as guaranteed under the CRC. The General Comment No.3 is concerned with gender-based discrimination, together with taboos or negative or judgmental attitudes to sexual activity of girls. This very often limits their access to preventative measures and other health services.[99] It says that States Parties should recognize in particular that girls are affected more severely by HIV/AIDS than boys.

As regards the best interests of the child (article 3 of the CRC), General Comment No.3 notes that the best interests of the child shall be a primary consideration.[100] According to the General Comment, general policies and programs for the prevention, care and treatment of HIV/AIDS are primarily designed for adults, rather than focusing on children and their best interests. Children should be put at the centre of the response to the HIV pandemic, and strategies and planning should be adopted to a holistic child's rights based approach.[101]

Concerning the right to survival, life and development (article 6 of the CRC), General Comment No.3 says that States are obliged to give careful consideration to the sexuality and lifestyles of teenagers. The General Comment affirms that girl-children are often subjected to early or forced marriages which violate their rights and make them more vulnerable to HIV/AIDS and other related illnesses.[102] This in turn often interrupts their access to proper education and information. As far as sexuality is concerned, children

[98] For a full discussion on the right to privacy, see Chapter 4, *infra*.
[99] General Comment No.3, op cit, para 6, p3.
[100] General Comment No.3, op cit, para 8, p4.
[101] General Comment No.3, op cit, para 8, p4.
[102] General Comment No.3, op cit, para 9,p4.

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should have access to appropriate sex education to equip them to protect themselves as well as others against HIV infection.[103]

The General Comment confirms that article 12 of the CRC affords children the right to participate in decisions affecting them, in accordance with their evolving capacities. Children further have a right to raise awareness by speaking out about the impact of HIV/AIDS on their lives and, more particularly, participate in the development of HIV/AIDS policies and programmes. Children benefit most if they are actively involved in devising and carrying out strategies and should be encouraged to become peer facilitators and educators both at school and outside school.[104] Children should also be actively involved at both community levels and national levels in HIV policy and programme initiatives, and also be able to share their experience with their peers and others so that they can prevent stigmatisation and discrimination and are able to lead normal lives after their involvement in policy decisions at both community and national levels.[105]

The Committee is of the view that health services do not cater adequately for the needs of persons aged below 18 years, and in particular, adolescents. Children are more inclined to use health-care services that are child-friendly, accessible, affordable, confidential, non-judgmental, do not require parental consent, and do not discriminate.[106] In the context of HIV/AIDS, and considering the evolving capacities of the child, States Parties should offer health services that employ trained personnel who fully respect children's right to privacy. Services should include voluntary counselling and testing, confidential sexual and reproductive health services, free or low cost contraception, condoms and services, as well as HIV-related care and treatment if and when needed, including treatment for the

[103] Sloth-Nielsen J, *Of Newborns and Nubiles: Some Critical Challenges to Children's Rights in Africa in the Era of HIV/AIDS* in International Journal of Children's Rights, Vol 13, 2005, pp 75-76.
[104] General Comment No.3 op cit, para 10, p 4.
[105] General Comment No.3, op cit, para 10, p4.
[106] General Comment No.3, op cit, para 17, p6; Sloth-Nielsen J, *Of Newborns and Nubiles: Some Critical Challenges to Children's Rights in Africa in the Era of HIV/AIDS*, op cit, p76.

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prevention of health problems related to HIV/AIDS, such as tuberculosis and other opportunistic infections.[107]

As it is the State's primary duty to ensure that children's privacy rights are protected, States must therefore refrain from imposing mandatory HIV/AIDS testing of all children in all circumstances and ensure protection against it. Where testing is undertaken on a voluntary basis, the evolving capacity of the child will determine whether the necessary consent is required from the child directly, or from a parent or guardian. Sufficient information must be given before testing to ensure that there is informed consent.[108] Test results must be kept confidential, in accordance with States' obligations to protect the child's right to privacy.

General Comment No.3, in addition to the four general principles of the CRC, provides a powerful framework to reduce the negative impact of the HIV pandemic on the lives of children. The human rights-based approach is the optimal tool for addressing the broader range of issues that relate to prevention, treatment and care strategies.

2.5 General Comment No.4 "Adolescent health and development in the context of the CRC."

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This General Comment sets out that privacy, confidentiality and consent form an integral part in safeguarding the rights of children, teens and adolescents. Children are especially vulnerable if they are tested for HIV without their consent. Disclosure of the nature and purpose of a medical procedure is one of the crucial requirements for the validity of informed consent. Yet children are exposed to medical procedures without their consent or they are given medication for one of the complications resulting from AIDS without knowing or being informed about the reason for taking the medication or the possible side effects of the medication. The next section will deal with adolescent health and development and the rights of adolescents in this regard.

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[107] General Comment No.3, op cit, para 17, p 7; Sloth-Nielsen J, *Of Newborns and Nubiles: Some Critical Challenges to Children's Rights in Africa in the Era of HIV/AIDS*, op cit, p76.
[108] General Comment No.3, op cit, para 20, p7.

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The principles covered in General Comment No.3 were reaffirmed in a subsequent General Comment on Adolescent Health and Development in the context of the CRC.[109] These include the obligation to safeguard by law the adolescent's right to medical treatment without parental consent, the adolescent's right to privacy and confidentiality of medical information, the obligation to take steps to raise the minimum age of marriage, and the need to provide access to essential information with regard to adolescent health and development. Of particular importance is that States Parties should provide adolescents with access to sexual and reproductive information, including information on family planning and contraception, regardless of parental consent.[110]

This General Comment confirms that it is essential to find proper means and methods of providing information relevant to the specific rights of adolescent girls and boys. States Parties are therefore encouraged to ensure that adolescents are actively involved in the design and dissemination of information through a variety of channels beyond school, including youth organizations, religious, community and other groups and the media.[111] The General Comment reiterates that adolescent girls should have access to information on the harm caused by early marriage and early pregnancy, and those who do become pregnant should have access to health services that are sensitive to their rights and particular needs. States are urged to foster positive and supportive attitudes towards adolescent parenthood and to develop policies that will allow adolescent mothers to continue their education.[112]

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Adolescents need to have a chance to express their views freely and their views should be given due weight, in accordance with article 12 of the CRC. However, if the adolescent is of sufficient maturity, informed consent to medical treatment shall be obtained from the

[109] General Comment No.4.
[110] General Comment No.4 op cit, para 28, p 8.
[111] General Comment No.4, op cit, para 28, p 8.
[112] General Comment No.4, op cit, para 31, p8.

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adolescent himself or herself, while informing the parents if that is in the best interests of the child (in accordance with article 3 of the CRC).[113]

The General Comment confirms that with regards to privacy and confidentiality, and the related issue of informed consent to treatment, States Parties should enact laws to ensure that confidential advice concerning treatment is provided to adolescents so that they can give their informed consent. It would be prudent if such laws stipulate an age for this process or refer to the evolving capacity of the child and to provide training for health personnel on the rights of adolescents to privacy and confidentiality.[114]

States are urged to develop ways to change cultural viewpoints about adolescent's needs for contraception and the prevention of sexually transmitted diseases, and to address cultural taboos around adolescent sexuality.[115] States, in exercising the obligations relating to health and development of adolescents, must take account of the four general principles of the CRC. States must ensure that adolescents always have access to information that is essential for their health and development and that they have opportunities to participate in decisions affecting their health (through informed consent and the right of confidentiality), to acquire life skills, to obtain adequate and age-appropriate information and to make appropriate health behaviour choices.[116]

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General Comment No.4 provides important guidelines which are essential for adolescent health and development especially in the context of HIV/AIDS.

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3. The African Charter on the Rights and Welfare of the Child

The Charter is the first binding regional instrument that gives recognition to children as possessors of certain rights. The Charter reflects the same minimum standards of the treatment of children as in the CRC. However, some provisions in the Charter offer a

[113] General Comment No.4, op cit, para 32, p9.
[114] General Comment No.4, op cit, para 33, p9.
[115] General Comment No.4 op cit, para 28, p7.
[116] General Comment No.4, op cit, para 39, p10.

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higher standard, thus not only complementing the CRC, but also ensuring a higher threshold for the promotion and protection of children's human rights.[117]

South Africa ratified the Charter on 7 January 2000. The Charter is one of the most progressive children's rights instruments in the world today. It makes provision for a broad range of economic, social and cultural rights as well as civil and political rights. It contains extensive provisions on children's rights to education, health care services, survival and development, and protection against harmful social and cultural practices.[118] It is interesting to note that the Charter (as well as the CRC) does not address the issue of HIV/AIDS and child-headed households. This is largely due to the fact that the Charter was drafted before the enormity and scale of the pandemic was fully comprehended.[119]

The African Committee of Experts on the Rights and Welfare of the Child,[120] established by the Charter, is an institution of the African Union (hereafter the AU). The Committee is composed of 11 members elected by the Assembly of Heads of State and Government of the African Union. The Committee's functions are to promote and protect the rights enshrined in the Charter, monitor their implementation and ensure their respect, interpret the provisions of the Charter at the request of the State Parties, institutions of the AU or any other institution, and, finally, to carry out any other duties entrusted to it by the Assembly of Heads of State and Government, the Secretary General of the AU or any other organ of the Organization. With respect to monitoring of implementation of the Charter, the Charter provides the following two procedures: The reporting procedure provides that every State Party should submit reports on the measures it has adopted within two years of the entry into force of the Charter, and thereafter every three years (two reports were received in December 2005).[121] It is interesting to note that the Charter

[117] Lloyd A, Regional Development on the Rights and Welfare of Children in Africa; A General Report on the African Charter on the Rights and Welfare of the Child and the African Committee of Experts. Unpublished, 2003.

[118] Bekker G, A Review of International Developments, Focus on Children's Socio-Economic Rights, *ESR Review,* September 2000, Vol. 2, No. 3, p1. http://www.communitylawcentre.org.za/cer/esr2000/2000sept_children.php Date accessed 23March 2005.

[119] Sloth-Nielsen J, *Realising the rights of children growing up in child-headed households*, op cit, p 8.

[120] The African Charter on the Rights and Welfare of the Child, Article 42: Mandate, p17 http:// www.africa-union.org/official_document/Treaties Date accessed 29 March 2005.

[121] Article 43(1) of the Charter.

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does not itself specify how the Committee will examine these reports. The second procedure is the complaints procedure. The Charter authorizes the Committee of Experts to receive complaints against states. Grievances against States Parties may concern any issue covered by the Charter, and may be submitted by any individual, group or non-governmental organization recognized by the AU, a member state or the UN. The complaints procedure provided for by the Charter is a significant step forward compared to the CRC[122] which has no such procedure (one complaint was received by the African Committee of Experts in December 2005). The final protective function of the Committee is related to the investigations procedure.[123] The Committee is empowered to resort to any appropriate method of investigation in respect of any issue covered by the Charter. [124]

3.1 General Principles

Olowu [125] points out that, like the CRC, the Charter is based on four pillars to guide its interpretation as well as to guide national programmes of implementation. These principles are non-discrimination (article 2 of the CRC; article 3 of the Charter), the best interests of the child (article 3 of the CRC; article 4 of the Charter), the right to life, survival and development (article 6 of the CRC; article 5 of the Charter) and the right of the child to participate in decisions affecting him or her (article 12 of the CRC; article 4(2) of the Charter).

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3.1.1 Article 3: Non-discrimination

The principle of non-discrimination is clearly established as an overriding principle. Children are entitled to equal enjoyment of the rights under the Charter, irrespective of

[122] The African Charter on the Rights and Welfare of the Child, Article 42: Mandate, p17.
[123] Article 45 of the Charter.
[124] Human Rights in the Administration of Justice, Chapter 3: The Major Regional Human Rights Instruments and their Mechanisms for their Implementation, University of Minnesota Human Rights Library, p8.
http://www1.umn.edu/humanrts/monitoring.adminchap3.html Date accessed 1 October 2005.
[125]Olowu D, *Protecting Children's Rights in Africa, A critique of the African Charter on the Rights and Welfare of the Child,* in *The International Journal of Children's Rights* 10:127-136, 2002, p128.

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who they are and who their parents are. There should be no discrimination as far as fortune (property in the CRC), birth or "other status" of the child, parent or legal guardian is concerned. Other status often refers to legitimate or illegitimate children.[126] Gose[127] emphasizes that only parents are mentioned in article 3 of the Charter. The very important concept of extended families in African tradition should at least have been included. This is particularly important especially when we deal with AIDS orphans who rely heavily on the support of the extended family if both parents have died because of HIV/AIDS or related illnesses. On the other hand, consideration must be given to children who have neither parents nor extended families and have to fend for themselves and their siblings in child-headed households.

3.1.2 Article 4: Best interests of the child

The Charter provides that in all actions concerning the child undertaken by any person or authority, the best interests of the child shall be "*the* primary consideration". This offers better protection for children than the CRC since the best interest principle under the Charter is the overriding consideration. In contrast the CRC regards the principle as "*a* primary consideration" meaning that other considerations are equally determinant.[128] Gose argues that the Charter "maximizes the influence of the best interests principle in proclaiming its supremacy over other considerations." The Charter "embraces Western culture rather than genuine African spirit but there is nothing wrong in learning from other cultural experiences and adopting the best of them as the need arises."[129]

The African Charter talks about actions "concerning the child" while the CRC relates to actions "concerning children". The latter can be construed as a broader concept. The best interests principle does not only have to be taken into account in the specific matter regarding an individual child but in all matters regarding children in general. Such an

[126] Chirwa DM, *The merits and demerits of the African Charter on the Rights and Welfare of the Child* in *International Journal of Children's Rights* Vol.10, 157-177 (2002), p160.
[127] Gose M, *The African Charter on the Rights and Welfare of the Child*, Community Law Centre, UWC, 2002, pp48-49.
[128] Chirwa DM, *The merits and demerits of the African Charter*, op cit, p160.
[129] Gose M, *The African Charter on the Rights and Welfare of the Child*, op cit, p26.

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interpretation gives a broader scope to the whole provision and ensures maximum safeguards for children. In this sense the wording of the CRC affords higher level of protection than the Charter.[130]

3.1.3 Article 5: Survival and development

The most basic component of the right to survival is the right to life and States Parties are under an obligation to protect the right to life of children.[131]

3.1.4 Article 14: Health and health services

It is regrettable that Article 14 makes no mention of addressing the HIV/AIDS pandemic in Africa. At the time of drafting the Charter the effects of the pandemic were not out of proportion, but considering the ravaging effects of HIV/AIDS on children and the rapid emergence of child-headed households right across Africa, it is clearly a health and social issue that needs to be prioritized.

Chirwa[132] states that Article 14 of the Charter provides for the right to enjoy the best attainable state of physical, mental and spiritual health. The Charter outlines the measures that States Parties have to follow for the full implementation of this right. In this respect the Charter exceeds the CRC in two ways. Firstly, the Charter is the first instrument that requires resource allocation in respect of health. Article 14 (g) obliges States Parties to integrate basic health service programmes into national development plans.[133] Secondly, the Charter includes two more measures than the CRC that States Parties have to take in order to realize the right to health fully. The first is to ensure the meaningful participation of non-governmental organizations (NGO's), local communities and the population in the planning and management of basic service programmes for children. The second measure is to ensure via technical and financial means, the mobilization of local community resources in the development of primary health care of children. These measures are

[130] Ibid, p26.
[131] Viljoen F, *The African Charter on the Rights and Welfare of the Child*, op cit, p 220.
[132] Chirwa DM, *The merits and demerits of the African Charter*, op cit, p162.
[133] Ibid, p162.

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extremely important because they involve the communities themselves in the planning and management of basic service programmes for children. The Charter is therefore one of the few instruments that expressly calls for the participation of the people in issues affecting their lives. Gose refers to article 23 (1) of the CRC which contains the right to health care services that no child should be deprived of. The Charter on the other hand, does not expressly provide for such a right, but assumes that a similar right is contained in the general right to the best state of health. Article 14 (2) (b) of the Charter imposes an obligation on the States Party to ensure necessary medical assistance and health care to all children. Article 14 (2) (c) and (d) oblige the State to ensure the provision of adequate nutrition and safe drinking water, and to combat diseases and malnutrition.

Article 14(2) (g) aims at the full realization of the right to health through special national development plans. Article 14(2) (i) and (j) ensures the basic management of primary health care programmes for children. Although it does not provide a specific right for the child, it is more of a guarantee of the participation of society.[134]

The Charter emphasizes the need to include African cultural values and experience when considering issues relating to the rights of the child in Africa. In terms of article 2 of the Charter, the protection of a child's rights approach should extend to all children below the age of 18.[135]

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3.1.5 Article 10: Privacy

Article 10 of the Charter dealing with the protection of privacy is similar in wording to article 16 of the CRC and reads as follows:

> "No child shall be subject to arbitrary or unlawful interference with his privacy, family, home or correspondence, or to attacks upon his honour or reputation, provided that parents or legal guardians shall have the right to exercise reasonable supervision over the conduct of their children."

[134] Lloyd A, *Regional Development on the Rights and Welfare of Children in Africa,* op cit, p3.
[135] Olowu D, *Protecting Children's Rights in Africa, A critique of the African Charter on the Rights and Welfare of the Child,*, op cit, p134.

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This article somewhat limits the child's right to privacy because it provides that parents or legal guardians have the right to supervise the conduct of their children, which implies a possible interference with privacy.

3.1.6 Article 4(2): Participation rights

Article 4(2) of the Charter is regarded as the equivalent of article 12 of the CRC and reads as follows:

> "In all judicial or administrative proceedings affecting a child who is capable of communicating his/her own views, [an] opportunity shall be provided for the views of the child to be heard either directly or through an impartial representative as a party to the proceedings, and those views shall be taken into consideration by the relevant authority in accordance with the provisions of appropriate law."

The notion that the child is autonomous in the Charter is peculiar because children in Africa are not generally perceived to be autonomous (this notion is derived from African culture and tradition). Children are often regarded as not being able to make their own decisions and thus deserving of protection. Decisions regarding children are often made by the older people in the extended family and children had to abide by those decisions. It is therefore appropriate that African children now have specific guarantees for their participation in addition to their right to privacy.[136]

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4. Conclusion

International human rights legislation has evolved dramatically since the adoption of the CRC and the Charter. In addition to General Comments No.3 and No.4, they provide the platform for ensuring that children's human rights are protected. The four general principles, which form the backbone of the children's rights philosophy, highlight the cardinal values of the CRC, whilst at the same time outlining the criteria that are laid down to monitor the progress that States make in the implementation of a children's

[136] Ibid, p128.

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rights approach. Children's right to non-discrimination deals with human rights principles aimed at protecting children and youth infected with and affected by HIV/AIDS from unfair discrimination. Although HIV/AIDS has not been included in any international or regional treaties, relevant resolutions and guidelines do exist, and specific provisions in the General Comments outlined above will apply to the situations of those living with or affected by HIV/AIDS.

Countries should make a concerted effort to incorporate treaty obligations into domestic legislation. Most countries still adopt a policy-based approach to HIV/AIDS rather than a human-rights-based approach.[137] To guide governments towards a more inclusive human-rights-based response, States Parties should include human rights provisions in all spheres or sectors. At present, there are very few sectors that mention stigmatization and discrimination. It would be far better for countries to comply with international and regional treaty obligations and domesticate the provisions of these treaties through national legislation. States should review and reform public health laws to ensure that they adequately address public health issues raised by HIV/AIDS and that they are consistent with international human rights obligations.[138]

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[137] Guideline 3, HIV/AIDS and Human Rights International Guidelines, Revised print, March 2003, p10.
[138] Ibid, p10.

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Chapter 3

Consent by children with specific reference to HIV testing and treatment

1. Introduction

Chapter two dealt extensively with the international law components of both the CRC and the African Charter concerning the rights of the child which related to the prohibition against discrimination (article 2 of the CRC), the best interests of the child (article 3 of the CRC) the rights of the child to survival and development (article 6 of the CRC), the right of the child to participate in decisions affecting him or her (article 12 of the CRC), the right of the child to privacy (article 16 of the CRC) and the right to health (article 24 of the CRC).

This chapter will focus on the question whether a child can consent to treatment with specific reference to HIV testing and treatment. It will further explore the relationship between the child's consent and parental consent. At the outset, this chapter will determine what constitutes the legal definition of consent as well as the nature of informed consent. This chapter will briefly refer to consent as it developed in the Roman Dutch Law, what the Constitutional Law position is regarding consent, and how the current legislation has developed.

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Before the whole question of consent of children with reference to HIV testing and treatment can be addressed, various issues around education and health have to be looked at. The CRC advocates that children should have adequate living standards, education and health care.[139] However, youth constantly face hazards that hugely increase their risk of HIV infection and need protection against these hazards especially in cases of sexual exploitation. AIDS is a huge challenge and educational programmes are aimed at reaching out to youth both in and out of school.

[139] Article 28 and article 24 respectively.

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Health promotion and especially HIV prevention awareness should be a priority as far as educational purposes are concerned, but sexual and reproductive functions are often not adequately dealt with. Education for today's youth should go beyond providing academic facts and biological presentations. Schools should help youth to obtain knowledge and life skills which will ultimately help them to manage their lives.[140] These life skills are important because they prepare the youth for the personal and societal responsibilities of adulthood. They will assist youth tremendously in making thoughtful, well-informed decisions that are essential not only for minimizing the risk of HIV transmission and infection, but also for handling the pressures of everyday life. These life skills are also important because they empower the youth to make informed sexual decisions free of coercion.[141] This will ultimately empower and enable youth to determine whether they should or should not consent to treatment with specific reference to HIV testing.

1.1 What is informed consent?

Everyone has the right to make fully informed and voluntary decisions about health care, and more especially about reproductive health care. This basic human right usually centres around two related concepts, namely, informed choice and informed consent.[142] Informed choice ensures that a person has the necessary information about methods and services, including their risks and benefits, that allows a person to make a fully informed decision about whether to obtain or decline treatment or services.[143] Informed consent is a more formal, legal process in which the individual is first fully informed and then gives consent, either verbally or in writing,[144] to receive a service.[145] For both informed choice and informed consent, the individual must understand the information provided and must

[140] Ibid, p 17.
[141] Ibid, p 17.
[142] Finger WR, *Choices Must Be Informed, Voluntary* in *Family Health International (FHI)*, Vol 21, No.2, 2002, p1. http://www.FHI.org/en/RH/Pubs/Network/v21_2/NW21-2informconst.htm Date accessed 23 March 2006.
[143] Ibid, p1.
[144] HIV Testing and Informed Consent- AIDS Law Project- Equality for All, http://www.alp.org.za/modules.php?op=modload&name=News&file=article&sid=46.,. Date accessed 23 March 2006.
[145] Finger WR, *Choices Must Be Informed, Voluntary* in *Family Health International (FHI)*, op cit, p1.

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voluntarily agree to receive the service.[146] In the past, doctors were considered to know best and usually made decisions on behalf of the patient.[147] Individuals now would normally make decisions, which are based on their own values and beliefs, themselves. This approach respects the individual's viewpoint or autonomy and facilitates the right to self-determination.[148]

Why then, is informed consent so important? Firstly, informed consent is a crucial component of the relationship between the patient and the health care worker or provider.[149] When consent is given, the patient generally gives permission for the health care worker to proceed with tests and medical treatment.[150] Informed consent generally refers to the capacity of the person to grant such permission with a reasonable understanding of tests and medical procedures. Written informed consent is required for more complex procedures such as surgery or operations, otherwise verbal informed consent is generally accepted as standard practice in the health care setting.[151] Informed consent is important because it acknowledges the right of the patient to have control over his or her body, and it also allows for procedures or operations to be conducted on a patient's body only with his or her permission.[152]

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[146] This thesis is based on desk-top research and does not involve the interviewing of volunteers to participate in this research.
[147] Howarth G, *Basic Informed Consent* in *The Medicine Journal*, March 2002, p1. http://www.medpharm.co.za/safp/2002/march/basic.html Date accessed 23 March 2006.
[148] Ibid,p1.
[149] Copello G, *Frequently Asked Questions in Medical Ethics,* Florida Infectious Disease Institute, University of South Florida College of Medicine, p1. http://www.idcenter.net/FIDI/webapp/Secure/FIDI/FAQMedicalEthics.htm Date accessed 1 April 2005.
[150] Ibid, p1.
[151] Ibid, p1.
[152] Ibid,p1.

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1.2 Development of consent under the common law

The doctrine of informed consent is well recognized as a legal doctrine both in South Africa and internationally.[153] The concept of informed consent forms an essential requirement for any medical intervention. Informed consent requires that doctors and other health professionals provide a patient with all the relevant information about a proposed procedure or treatment before obtaining the consent of the patient in order to carry out the proposed procedure or treatment.[154] In order for consent to be valid, the patient must be provided with enough information concerning the "nature and implications of the proposed treatment; its alternatives and the possible consequences of no treatment." [155] A doctor is obliged to warn a patient undergoing medical treatment of the inherent risks or material risks that may be encountered whilst undergoing medical treatment. Knowledge of material risks becomes vital especially in cases where, had a patient known of the risks involved in a particular procedure, the patient might have opted for an alternate procedure or might have decided not to undertake medical treatment at all. Our courts have decided a number of cases that deal with material risk. In the case of *Castell v De Greeff,* [156] the court held that:

> "for a patient's consent to constitute a justification that excludes the wrongfulness of medical treatment and its consequences, the doctor is obliged to warn a patient so consenting of a material risk inherent in the proposed treatment; a risk being material if, in the circumstances of a particular case:
>
> (a) a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it; or

[153] The doctrine of informed consent was recognised as a legal concept in the judgment of the war crimes tribunal during the Nuremburg Trials in the 1930's and 1940's where doctors who were involved in crimes excused themselves by arguing that there were no clear rules on medical research on human beings in Germany.

[154] Veriava F, *Ought the Notion of "Informed Consent" to be Cast in Stone? VRM v The Health Professionals Council of South Africa,* in *South African Journal of Human Rights*, Vol 20, No.1- 4, 2004, p309.

[155] Giesen D, *From Paternalism to Self-determination to Shared Decision-making* in *Acta Juridica,* published under the auspices of the Faculty of Law, University of Cape Town 1988, pp 107, 112.

[156] 1994 (4) SA 408 (C).

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(b) the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it."[157]

In a recent decision by the Cape High Court in *Oldwage v Louwrens* [158] the question of informed consent and material risks in South African law was discussed. The court was also required to determine issues of professional medical negligence and assault, as a result of the absence of informed consent, by the defendant which stemmed from an incorrect medical intervention. The court in its judgment referred to the principles set out in *Castell v De Greeff,* which determine the basis for whether or not informed consent by a patient existed prior to the application of a medical procedure by a medical practitioner.[159] The court found that these principles are consistent with the Constitutional rights to individual autonomy and self-determination.[160] The principle of informed consent is therefore one that is based on "substantial knowledge" which must exist on behalf of the patient. A medical practitioner is thus obliged to warn a patient of the material risks and consequences which may ensue during and consequent to the proposed treatment.[161] The court further noted that even if a determination of assault failed, in the absence of informed consent, it may amount to an invasion of the right to privacy in terms of section 14 of the Constitution.[162] However, on appeal, the Cape High Court's decision was set aside and it was found in favour of the defendant, based on medical evidence supplied by expert witnesses, confirming that the risk that occurred was too minimal and remote to be substantial and could thus not cause any harm to the plaintiff. The Supreme Court of Appeal (the SCA) did not consider the opinions of the medical experts regarding the materiality of the risks based on the likelihood of it occurring:

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[157] In *Castell v De Greef,* one of the issues in the case was whether the defendant had failed to warn the plaintiff of material risks and complications of the operation (mastectomy). The plaintiff alleged that if the risks and the operation been fully disclosed to her, she would not have undergone the operation but would rather have chosen another surgical procedure instead. However, the court found that the plaintiff had been made fully aware of the risks of the operation.

[158] [2004] 1 All SA 532 (C).

[159] For consent to operate as a defence, the following requirements must be met: (a) the patient must have had knowledge and been aware of the nature of the harm or risk; (b) the patient must have appreciated and understood the nature and extent of the harm and risk; (c) the patient must have consented to the harm and assumed risk; (d) the patient's consent must be comprehensive, that it extends to the entire transaction, inclusive of its consequences.

[160] Para 90, p556.

[161] Para 87, p555.

[162] Para 98, p558.

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"If there was only a two percent chance of [the risk] occurring then the risk to the plaintiff was so negligible that it was not unreasonable for the defendant not to mention it."

The SCA further held that the likelihood of the risk was so negligible that no duty arose on the defendant to mention it.[163] The SCA judgement is very disappointing and is contrary to the well-established principles set out in the previous cases.

A person has a common law right as well as a constitutional right to bodily integrity and security. A person is required to consent to treatment and at the same time has the right to refuse treatment.[164] Our courts, when dealing with the doctrine of informed consent, are abandoning the previous paternalistic approach that the doctor always knew what was best for the patient. The approach now emphasizes the patient's concerns, understanding and appreciation of the specific treatment being consented to.[165] It is for the patient to decide whether or not he or she wishes to undergo an operation or treatment,[166] because the patient's rights of bodily integrity and autonomy entitle him or her to refuse medical treatment.[167]

Although the concept of informed consent is regarded as part of Roman-Dutch common law principles, [168] it was only recently defined by the South African courts.[169] The courts however, have referred to the concept previously:

"The concept is, however, not alien to our common law. It forms the basis of the doctrine of *volenti non fit injuria* that justifies conduct that would otherwise have constituted a delict or crime if it took place without the victim's informed consent. More particularly,

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[163] Para 87, p555.

[164] Dinnie D, *South African National Blood Services- Medical and Business Ethics Workshop- Medico-Legal Principles in Decision Making,* 14 October 2002, p2.
http://www.deneyreitz.co.za/news/news.asp?ThisCat=28ThisItem=104 Date accessed 24 March 2006.

[165] Ibid, p2.

[166] Similar tests to determine whether or not there has been consent are also followed in other countries under the doctrine of the doctor's duty of care towards the patient. In Australia, in *Rodgers v Whitaker* (1993) 67 ALJR 47, the doctor had a legal duty of care to warn a patient of the material risk involved in a proposed treatment.

[167] Veriava F, *Ought the Notion of "Informed Consent" to be Cast in Stone? VRM v The Health Professional Council of South Africa*, op cit, p313.

[168] Hockton A, *The law of consent to medical treatment*, Sweet & Maxwell, London 2002, pp 2-4.

[169] *C v Minister of Correctional Services* 1996 (4) SA 292 (T), p293.

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day to day invasive medical treatment, which would otherwise have constituted a violation of the patient's right to privacy and personal integrity, is justified and is lawful only because as a requirement of the law, it is performed with the patient's informed consent."[170]

Although most Roman-Dutch writers and cases regard informed consent as a defence to a delictual claim against a health care professional, it is no longer enough.[171] Each person has a fundamental right to bodily integrity and individual autonomy, therefore informed consent is required from every competent person, whether adult or child, before any medical procedure is started.[172]

In South African law, informed consent falls under the defence of *volenti non fit iniuiria,* in terms of which a patient' s informed consent is a justification for conduct that would otherwise constitute a wrongful delictual act.[173] A patient's consent for the performance of any medical treatment, whether it is therapeutic, non-therapeutic or diagnostic, is currently universally and generally accepted as a necessary prerequisite. Society regards the individual's right to physical integrity and to self-determination very highly.[174] In the case of *Stoffberg v Elliot*[175] recognition is given to the individual's personality and free will:

> "In the eyes of the law every person has certain absolute rights which the law protects. They are not dependent on statute or on contract, but they are rights to be respected, and one of these rights is absolute security to the person… Any bodily interference with or restraint of a man's person which is not justified in law, or excused in law or consented to, is a wrong…"[176]

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[170] *Christian Lawyers' Association v Minister of Health and Others*, 2005 (1) SA 509 (TPD).
[171] *Children and Informed Consent to HIV/AIDS Testing and Treatment in Botswana*, p9. (copy on file with author).
[172] Ibid, p9.
[173] *Stoffberg v Elliot* 1923 CPD 148.
[174] Oosthuizen H, *National Policy on Testing for HIV* in *The Medicine Journal*, October 2001, p1. http://www.medpharm.co.za/safp/2001/oct/hiv.html Date accessed 13 September 2005.
[175] 1923 CPD 148.
[176] Ibid, p148.

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1.3 Requirements for obtaining consent

The question of who may consent to treatment of HIV infected orphans and children who are in desperate need of life saving antiretroviral treatment becomes a pertinent one especially in light of the fact that the number of AIDS orphans is increasing at an alarming rate.

There are three rules that must be observed for a doctor to obtain consent, namely
(1) the doctor must obtain consent from the person legally competent to give consent
(2) the doctor must obtain an informed consent
(3) the doctor must obtain a clear, unequivocal and comprehensive consent.[177]

As far as the first requirement is concerned, there are generally no problems in obtaining consent in the case of adults, as long as the person is of sound mind. If the person is intoxicated, under the influence of drugs, unconscious or in a complete state of shock, then he or she will be legally incapable of giving consent.[178] Consent to medical treatment or operations on mentally ill patients must be obtained either from a curator, appointed by the court to look after the person or property of the patient, or from the patient's spouse, parent, major child, brother or sister.[179] Where the patient is a minor,[180] then the parent or guardian (if available), gives consent. In the case of orphans or adopted children, the legal guardian may consent. Where the parents request an operation which is medically necessary, but the minor refuses to have an operation, the doctor can generally depend on parental consent.[181] An exception to this rule, is when a girl under 14 chooses

[177] Strauss SA, *Doctor, Patient and the Law*, A selection of practical issues, Third edition, 1991, JL van Schaik, p4.
[178] Ibid, p5.
[179] This is in terms of section 60 A of the Mental Health Act 18 of 1973. This is now governed by section 33 of the Mental Health Care Act 17 of 2002.
[180] A minor in this context would be an unmarried person below the age of 21 years.
[181] Strauss SA, *Doctor, Patient and the Law*, A selection of practical issues, op cit, p5.

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to have an abortion in terms of the Choice on Termination of Pregnancy Act (hereafter the CTOPA)[182] where no parental consent is required.

What is the position when a child needs an operation or medical treatment, but the parents refuse to consent based on religious grounds? Section 39(1) of the Child Care Act[183] provides that where a doctor feels that it is necessary to operate or for a child to have treatment, and the parent or guardian refuses to consent, the doctor should report the matter to the Minister of Health and Welfare, who then consents on behalf of the parent or guardian.[184]

Can a minor independently consent to an operation or treatment? Section 39(4) of the Child Care Act[185] makes it possible for a minor who is 18 years of age or older, to independently consent to medical treatment or to the performance of an operation upon himself.[186]

The second requirement is to obtain an informed consent. Two of the basic elements of consent are knowledge and appreciation. As a general rule the patient must be fully aware of what he or she is consenting to. Generally the patient must be made aware that medical procedures involve a certain amount of risk, and the patient must be made aware of the nature of the treatment proposed.[187] In *VRM v The Health Professions Council of South Africa,*[188] the plaintiff alleged that the doctor conducted an HIV test without her consent. The doctor did not disclose the plaintiff's HIV status at a consultation where both the plaintiff and her husband were present. Furthermore, he failed to advise the plaintiff on ways to reduce the risk of mother-to-child transmission during the birth, after he knew of

[182] Act 92 of 1996.
[183] Act 74 of 1983.
[184] Strauss SA, *Doctor, Patient and the Law*, A selection of practical issues, op cit, p6.
[185] Section 39(4) provides that: (a) any person over the age of 18 years shall be competent to consent, without the assistance of his parent or guardian, to the performance of any operation upon himself; and (b) any person over the age of 14 years shall be competent to consent, without the assistance of his parent or guardian, to the performance of any medical procedure on himself or his child.
[186] The Child Care Amendment Bill of 1991 changed the statutory age of consent to medical treatment to 14 years. For a full discussion on section 39(4) of the Child Care Act, refer to Chapter 5 *infra* dealing with Legislation and Law Reform.
[187] Strauss SA, *Doctor, Patient and the Law*, A selection of practical issues, op cit, p 12.
[188] TPD 1679/2002 (10 October 2003) unreported.

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her HIV status. The fundamental issue between the parties was whether or not there was informed consent for the patient's blood to be tested for HIV. If the ethical guidelines, as required by the Health Professions Council of South Africa (hereafter the HPCSA) had been followed in obtaining *VRM's* informed consent, she would have understood the risks to her unborn child and she would have made autonomous decisions from the start of the pregnancy. The lower court was of the view that the difference between consent and informed consent was marginal.[189] It also described the HPCSA guidelines as "not cast in stone."[190] However, it is submitted that in the present context of the rapid spread of HIV/AIDS, ethical rules regarding informed consent should be cast in stone and should be binding on members of the medical profession.[191]

In *C v Minister of Correctional Services*[192] the Department of Correctional Services had adopted the concept that informed consent was a prerequisite for testing prisoners for HIV and specified what norms were applicable.[193] Informed consent regarding HIV/AIDS testing was formulated clearly in this case, where it was stated as follows:

> "It is axiomatic that there can only be consent if the person appreciates and understands what the object and purpose of the test is, what an HIV positive test is, what an HIV positive result entails and what the probability of AIDS occurring thereafter is. Evidence was led in this case on the need for informed consent before the HIV test is performed... Because of the devastation which a positive result entails, the norm so developed contains as a requirement counselling both pre- and post-testing, the latter in the event of a positive result."

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[189] Strauss SA, *Doctor, Patient and the Law*, A selection of practical issues, op cit, p 12.
[190] Veriava F, *Ought the Notion of "Informed Consent" to be Cast in Stone? VRM v The Health Professionals Council of South Africa,* op cit, p316.
[191] Ibid, p316.
[192] 1996 (4) SA 292 at p 293.
[193] According to these norms, prisoners who had been involved in high risk behaviour had to receive pre- and post-test counselling and the prisoners' informed consent had to be obtained before the HIV test was done.

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The third requirement is to obtain a clear, unequivocal consent. Generally the doctor should ensure that the patient knows exactly what he or she has consented to.[194] Medical treatment comprises a certain number of risks and the patient must be informed about the risks and must be left in no doubt that he or she is prepared to undergo the treatment notwithstanding the risk.[195] Doctors would normally require the consent to be written and signed and at the same time the nature of the treatment is spelled out or described in detail. If a medical practitioner through his or her wrongful and negligent conduct causes damage to a patient, the practitioner will be delictually liable to the patient if there was a causal connection between the conduct of the practitioner and the damage suffered by the patient. The medical practitioner cannot be held liable if his or her conduct has not caused any damage.[196]

1.4 The relationship between the child's consent and parental consent

One of the most salient features in the development of children's jurisprudence can be described as a re-definition of the parent-child relationship, with the recognition of children as autonomous persons.[197] This is reflected in both the CRC[198] and the African Charter.[199] Recognition of the child's autonomy attests to the maturation and development of the child. However, conflict arises between parental authority and the protective role that parents play, and the minor's right to exercise his or her autonomy.[200] Parents may strongly object to their daughters receiving contraceptive or abortion treatment without parental consent, whereas the child who is sexually active may require such contraceptive or abortion treatment. The minor may feel that she is competent and sufficiently mature to consent to such treatment, whereas the parent may feel that he or

[194] Strauss SA, *Doctor, Patient and the Law*, A selection of practical issues, op cit, p12.
[195] Ibid, p12.
[196] *Mcdonald v Wroe*, Case number 7975/03 (judgment delivered 6 March 2006), CPD, p5.
[197] Ngwena C, *Health care decision-making and the competent minor: the limits of self-determination* in *Children's Rights,* edited by Keightley R, 1996, Juta & Co, p132.
[198] Article 12.
[199] Article 4(2).
[200] Ngwena C, *Health care decision-making and the competent minor: the limits of self-determination.,* op cit p133.

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she has the authority and the responsibility to make such decisions on behalf of the minor.[201]

International jurisprudence has shifted away from protecting the rights of parents to a consideration of the best interests of children and to allow children to participate in decisions affecting their lives. It is these two principles that must be the primary consideration in all decisions and actions that may affect the present and future of children, especially in the context of informed consent to HIV/AIDS testing and treatment.[202] In Britain, teenagers say that they are not sufficiently involved with the decision-making process when receiving treatment. Many children and teenagers feel that they have the right to participate in decisions concerning their treatment rather than being mere recipients of care. They also feel that their voices should be heard and they want to be involved, informed and consulted when using health care facilities and services.[203]

As far as medical issues arising from adolescent sexuality is concerned, in English law,[204] young people 16 and 17 years of age have the legal capacity to consent to any surgical, medical or dental treatment without parental consent. This in fact gives 16 and 17 year olds complete independence in medical decision-making.[205] Problems generally arise with children under 16 years of age where major issues are involved. [206]

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What was the common law position of minors and consent to treatment? At common law all minors were incompetent to consent to treatment independent of their parent (or

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[201] Ibid, p134.
[202] Ibid, pp134-5.
[203] Odigwe C, *Children say they are not involved enough in their treatment* in *British Medical Journal*, Volume 328, 13 March 2004, p600. http://bmj.com/cgi/content/full/328/7440/600-b Date accessed 21 November 2005.
[204] Section 8 (1) of the Family Law Reform Act 1969.
[205] Bainham A, *Children and Medical Decisions*, Chapter 8 in *Children: The modern law*, Third edition, p 345.
[206] *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] 1 AC 112. This English case dealt with medical decision-making and whether or not the child had capacity to give or refuse consent. The court held that the child must be able to understand the nature of the advice which she was given (Bainham A, *Children and Medical Decisions,* Chapter 8 in *Children: The modern law,* op cit, p346).

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guardian).[207] Boberg[208] and Strauss have different views in this regard. Boberg is of the opinion that there is very little authority on the capacity of a minor to give an effective consent in South African Law.[209] In *Eggeling v Law Union & Rock Insurance Co. Ltd*[210] it was assumed that a parent or guardian could consent to assume a risk on behalf of his or her child.[211] Boberg further states that:

"inasmuch as consent amounts to a waiver or abandonment of rights that would otherwise attach to the consenting party, it is an inherently prejudicial act for which a minor should, in principle, require the intervention or assistance of his or her guardian."[212]

This is in accordance with the Roman law principle that without his or her guardian's assistance a minor can only improve his or her position, not worsen it.[213] Roman-Dutch common law favoured the protection of parental rights right until the minor's attainment of majority. However, as stated earlier in this thesis, the emphasis in the parent-child relationship has since been shifting away from protecting parental rights as intrinsic rights towards protecting the minor's best interests and affording recognition to the minor's autonomy.[214]

Our courts have dealt with the whole question of patients' rights to self-determination and autonomy in *Castell v De Greeff*.[215] Ackerman J made it clear that the *ratio* for the requirement was "to give effect to the patient's fundamental right to self-determination". The court further re-iterated that it was

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[207] Van Heerden B, Cockrell A, Keightley R, *Personal and Proprietary Aspects of the Parental Power* in Boberg's *Law of Persons and the Family*, Second edition, Juta & Co, Ltd, 1999, pp683-4;
Keyser B, *Law of Persons and Family Law* in *Annual Survey of South African Law* (1991) p1 at p4.
[208] Van Heerden B, Cockrell A, Keightley R, *Personal and Proprietary Aspects of the Parental Power* in Boberg's *Law of Persons and the Family*, op cit, p849.
[209] *Johannesburg City Council v Venter* 1936 TPD 287 at 291.
[210] 1958 (3) SA 592 (D) at 597.
[211] Van Heerden B, Cockrell A, Keightley R, *Personal and Proprietary Aspects of the Parental Power* in Boberg's *Law of Persons and the Family*, op cit, p849.
[212] Ibid, p849.
[213] *Silberman v Hodkinson* 1927 TPD 562 at 570.
[214] Ngwena C, *Health care decision-making and the competent minor: the limits of self-determination.*, op cit, p141.
[215] 1994 (4) SA 408 (C).

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"clearly for the patient to decide whether he or she wishes to undergo the operation, in the exercise of the patient's fundamental right to self-determination." [216]

He further emphasized that

"it is in accord with the fundamental right of individual autonomy and self-determination to which South African law is moving. This formulation also sets its face against paternalism, from many other species whereof South Africa is now turning away."[217]

The Constitution contains a number of provisions aimed at protecting the health rights and bodily integrity of individuals. Section 12[218] combines a right to freedom and security of the person with a right to bodily integrity. This right is an important innovation in the 1996 Bill of Rights.[219] The inclusion of this right places emphasis on the power to make decisions concerning reproduction as a crucial aspect of control over one's own body. This right underscores the provisions regarding abortion as set out in the Choice on the Termination of Pregnancy Act (hereafter the CTOPA).[220]

The views of minors are accorded weight in terms of their age and maturity.[221] The courts recognize that as children grow older and approach majority, they are more capable of making their own decisions.[222] The courts are increasingly regarding children's rights not as intrinsic rights but as responsibilities or duties owed towards the child and these responsibilities will be upheld only to the extent that they are needed to protect the child.[223] Therefore Professor Boberg's view is not exactly in touch with today's reality where many children are not living with their parents and as such, have frequently to make decisions concerning their treatment.

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[216] Supra at 420 J.
[217] Supra at 426 E.
[218] Section 12(2) states that everyone has the right to bodily and psychological integrity, which includes the right (a) to make decisions concerning reproduction (b) to security in and control over their body.
[219] Currie I, De Waal J, *Freedom and Security of the Person,* Chapter 12 in *The Bill of Rights Handbook*, fifth edition, 2005, p308.
[220] Act 92 of 1996.
[221] *Germani v Herf and Another* 1975 (4) SA 887 (A).
[222] *Meyer v Van Niekerk* 1976(1) SA 252 (T).*Coetzee v Meintjies* 1976 (1) SA 257 (T).
[223] Ngwena C, *Health care decision-making and the competent minor: the limits of self-determination,,* op cit, p141.

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On the other hand, Professor Strauss'[224] view is more in touch with reality and in line with modern legal systems. Modern jurisdictions[225] do not presume that minors are irrebuttably incompetent to consent to treatment.[226]

As far as the issue of abortion is concerned, the provisions of the Children's Bill regarding consent are subject to the provisions of section 5(2) of the CTOPA[227] which stipulates that "no consent other than that of the pregnant women shall be required for the termination of a pregnancy." This effectively means that a girl can consent to have an abortion performed without parental consent and/or knowledge, although she must be advised to consult with them beforehand.

An interesting case dealing with the right of minors to consent to a termination of pregnancy was *Christian Lawyers' Association v National Minister of Health and*

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[224] Strauss SA, *Doctor, Patient and the Law*, A selection of practical issues, op cit, p14.

[225] Ngwena C, *Health care decision-making and the competent minor: the limits of self-determination, op* cit, p142. In the *Gillick* case (infra) the House of Lords was asked to declare, whether at common law a girl under 16 years of age could consent to contraceptive treatment independent of her parents. The issue was raised against the background of a statutory provision, section 8(1) of the Family Reform Act (1967) which states that a minor who is 16 years old is competent to consent to any treatment. Section 8(1) reads as follows:

"The consent of a minor who has attained the age of sixteen years to any surgical, medical or dental treatment which, in the absence of consent, would constitute trespass to his person, shall be as effective as it would be if he were of full age; and where a minor has by virtue of this section given an effective consent to any treatment it shall not be necessary to obtain any consent for it from his parent or guardian." The House of Lords refused to interpret section 8(1) as implying that a minor under 16 years was incompetent to consent to treatment at common law. Instead, the House of Lords regarded section 8(1) as merely declaratory of common law and held that it was a question of fact in each case whether a minor under 16 had the competence to consent. It depends on whether she had the required intelligence and maturity to appreciate the significance of the treatment. The House of Lords further emphasized that parental rights should be exercised in such a way that it is not incompatible with the recognition of autonomy of the child. The House of Lords reaffirmed the dictum in *Hewer v Bryant* [1969] 3 All ER 578 at 582, where it was held that the parental right to control a child begins with "absolute power", but becomes "a dwindling right", as the child gets older.

The United States follows a view similar to that of Professor Strauss. The American Constitution gives parents substantial autonomy and discretion with regards to making decisions relating to treatment for their children. In *Prince v Massachusetts* 321 US 158, the court held that parents are the most appropriate decision-makers for their children, and that to interfere with how they raise their children would be a violation of the constitutionally implied right to privacy of the parents. It should be noted that the Supreme Court has not given parents absolute rights in respect of medical treatment. It held that there has to be a balance between the parents' legitimate interests in making private and independent decisions, provided that the parent has the required capacity. Minority, therefore, does not automatically bar one from consenting to treatment without the consent of the parent. Children as young as 12 years of age were held to be competent to refuse treatment for mild cases of epilepsy. (*Prince v Massachusetts)*

[226] Ibid, p141.

[227] Act 92 of 1996.

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Others.[228] This case involved a challenge to the right given to minors by the CTOPA that allowed them to terminate their pregnancies without parental consent. Section 5(3) of the Act stated that in the case of a pregnant minor, a medical practitioner or a registered midwife, shall advise such a minor to consult with her parents, guardian, family members or friends before the pregnancy is terminated: provided that termination shall not be denied because such minor chooses not to consult with them. The action was brought by the Christian Lawyers' Association (hereafter the CLA) who argued that section 5(3) was in conflict with the Constitution because it infringed the right of every child to family and parental care.[229] They further argued that minors are not capable of making informed decisions about abortions without parental consent. They based their argument on the effects of abortion on a minor, the vulnerability of the minor when making such decisions and both the changes in the developmental stages of a minor and the effects of such changes. Because of these special considerations, they believed that a pregnant minor deserves special State protection which required that the State ensure that she is not deprived in any way of the support, guidance and care of her parents or guardian. The court held however, that the plaintiff's argument neglected to take into account the CTOPA's requirement that consent to an abortion had to take place with the informed consent of the pregnant woman. In many cases adequate informed consent could be given by a child under 18 and, in cases where the child was not sufficiently mature to make an informed decision without parental assistance, a child's decision to terminate her pregnancy would not meet the CTOPA's threshold requirement for valid consent.[230] The court observed that the Constitution recognizes and protects the right to termination of pregnancy in terms of section 12(2)(a) of the Constitution relating to the right to bodily and psychological integrity, which includes the right to make decisions concerning reproduction, as well as in terms of section 12(2)(b) of the Constitution, which recognizes the right to control over one's body.[231]

[228] 2004 (10) BCLR 1086 (T).
[229] Section 28 (1)(b) of the Constitution which states that every child has the right to family care or parental care.
[230] At p1098.
[231] At p1086.

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Children's health care rights and access to vital health care services are promoted and protected in the Constitution. Section 27(1)(a) of the Constitution entitles everyone to have access to health care services, including reproductive health care. This section should be read with section 27(2) of the Constitution.[232] Furthermore, bodily and psychological integrity and the right to security and control over one's body are also protected. These rights equip woman and children with enough information to exercise a choice in health care and the ability to freely give or refuse consent for treatment.[233] These rights are extremely important because children and teenagers are exposed to many health risks at an early age, more so in the light of the spread of HIV infection as a result of child rapes, sexual abuse, and also the myth that if an HIV positive person has sex with a virgin, then he will be cured of AIDS.[234] Furthermore, rape survivors who face these health risks must be adequately informed to enable them to make choices on the appropriate treatment to deal with such risks.[235] One of the best ways to provide such information is via general public health messages and through all educational institutions so that everyone is aware of the range of services available in a crisis.[236]

2. Children and access to anti-retroviral treatment

Consent to obtain anti-retroviral treatment is often very problematic especially in cases of AIDS orphans who have no parents or guardians who can consent on their behalf. This lack of consent can compromise the health of seriously ill children whose only hope of improving their health is by taking much needed anti-retroviral drugs. The HIV pandemic to date is one of the biggest and has the most serious infectious diseases that has affected South African children. Children that become infected can progress to getting HIV/AIDS, thus they require anti-retroviral (ARV) treatment to defer the onset of AIDS, as it

[232] Section 27(2) states that the State must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.
[233] Cook R, *Women's Health and Human Rights,* World Health Organisation, Geneva, 1994, p25.
[234] Ibid, p25.
[235] Meerkotter A, *Violence against young women and HIV/AIDS: Access to post-exposure prophylaxis after rape in South Africa,*Community Law Centre, University of the Western Cape, 2002, p7.
[236] Ibid, p7.

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eventually and invariably leads to death.[237] In November 2003 the South African government, represented by the Department of Health, approved an HIV/AIDS care and treatment plan[238] to address a wide spectrum of health issues for adults and children living with HIV/AIDS, including implementing the roll-out of ARVs.[239] In cases where children contract HIV, it is imperative to note that children with HIV infection have the same general health needs as those children without HIV infection. In addition to these general health needs, however, they also have specific health needs which are more diverse and complicated.[240] In *Minister of Health v Treatment Action Campaign,*[241] the Government adopted and implemented a policy which piloted the anti-retroviral drug Nevirapine which is recommended to reduce mother-to-child-transmission (MTCT) of HIV/AIDS. Access to Nevirapine was only given to HIV infected pregnant women in 18 research and training pilot sites. In terms of the policy, doctors in public hospitals could not prescribe Nevirapine to pregnant mothers outside of the pilot sites. The Treatment Action Campaign (hereafter the TAC) challenged the Government's policy and argued that it violated the right of access to health care services of pregnant women with HIV/AIDS, including reproductive health care services, that it violated the right of children to basic health care services and that it failed to adopt a comprehensive response to the prevention of MTCT of HIV. The Constitutional Court ruled in favour of the TAC and ordered the Government to allow Nevirapine to be given in hospitals other than those in the pilot sites. All women, irrespective of their HIV status, have the right to determine the course of their reproductive health. This is entrenched in the Bill of Rights which states that everyone has the right to life; and everyone has the right to have to access to health care services, including reproductive health care.

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[237] Shung-King M, Abrahams K, Berry L, *Child health: HIV/AIDS* in South African *Child Gauge* 2005, Children's Institute, University of Cape Town, edited by Jacobs M, Shung-King M and Smith C, 2005, p59.
[238] Known as the Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa.
[239] Shung-King M and Roux P, *Children and anti-retroviral roll-out: Towards a comprehensive approach* in South African *Child Gauge* 2005, Children's Institute, University of Cape Town, edited by Jacobs M, Shung-King M and Smith C, 2005, p21.
[240] Ibid, p23. Examples of specific health needs are prevention of opportunistic infections such as pneumonia and tuberculosis, and treatment of gastroenteritis.
[241] 2002 (5) SA 721 (CC).

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Children with HIV infection need preventative and treatment medicines for treating HIV-related infections, including access to ARVs. Children who are in need of ARVs and have access to ARVs, can improve their health and quality of life, which in turn reduces the need for expensive in-patient hospital care. In this way hospitals can use their already stretched to the limit resources more efficiently for other patients because children on ARVs stay in hospital for shorter periods of time.[242]

Hospital beds are thus more freely accessible and available to other acutely ill children whether or not they are infected with HIV/AIDS.[243] Presently, South African children with HIV/AIDS are only identified as candidates for ARV treatment if they become seriously ill.[244] This situation can be remedied by early diagnosis of infection in children who are suspected to have HIV, and by putting in place appropriate preventative measures.[245]

Adherence to ARV treatment is not always as smooth and easy as one would imagine, and children encounter many problems in this regard. A child who is on ARV treatment whose mother has died suddenly, will severely compromise the adherence to ARV treatment.[246] It is alleged that comprehensive care for the child therefore requires close attention to maternal health.[247] Furthermore, poverty is also a contributory factor to poor adherence to regular medicine schedules which require a well-regulated life. Poverty worsens the effects of HIV/AIDS in homes and HIV/AIDS in turn exacerbates already existing poverty.[248] These effects can be seen in both urban and rural areas. In urban areas, people living with HIV/AIDS experience a serious drop in household income, whereas in rural areas, agricultural activity and output decreases or grinds to a halt altogether.[249]

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[242] Ibid, p26 of case.
[243] Ibid, p26.
[244] Ibid, p26.
[245] Ibid, p27.
[246] Ibid, p27.
[247] Ibid, p27.
[248] Ibid, p22.
[249] Ibid, p22.

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Children who do not have adult care-givers are placed under tremendous strain, because the current criteria require children to have at least one responsible adult who cares for them before they are placed on the ARV treatment program.[250] It is immensely difficult for children to take on this huge responsibility for younger siblings and to ensure that they take their medication daily and in the correct dosage. This would largely depend on the age of the older children in the household, as well as the living conditions that prevail.[251] Adherence requires vigilance and persistence and it is extremely difficult for children to watch the clock to ensure that a dose is administered twice a day, twelve hours apart. Getting medication and utensils prepared and measuring exact amounts; finding someone to hold the baby or toddler; scooping up medicine that is spat out and watching for one hour to see that the medicine stays down and is not vomited out, have also added burdens.[252]

2.1 Barriers to anti-retroviral treatment

Children who need ARV treatment may encounter barriers which need to be overcome both from the perspective of children and care-givers as well as the health care system.[253] Access to the health care system is difficult, especially for unaccompanied and refugee children. HIV positive parents do not disclose their status or get children tested before they die. Furthermore, sexually abused children have great hardship in accessing post-exposure prophylactic (PEP)[254] ARV treatment within 72 hours of the sexual assault and are often returned to the abusive environment.[255] There are frequently lengthy delays

[250] Blanckenberg N, *Access to Paediatric HIV/AIDS Treatment,* ChildrenFIRST, Issue 60, March/April 2005, p5. http://www.childrenfirst.org.za/shownews?mode=content&id=24411&refto=4685 Date accessed 4 March 2006.
[251] Ibid, p5.
[252] Ibid, p5.
[253] A National Consultation on Paediatric HIV/AIDS Treatment Advocacy, held in Durban on 31 January 2005, ChildrenFIRST, Issue 60, March/April, 2005, p1. .http://www.childrenfirst.org.za/shownews?mode=content&id=24413&refto=4685 Date accessed 4 March 2006.
[254] Post-exposure prophylactic drugs are administered to rape survivors and sexual violence survivors to prevent contracting HIV from an attacker after the rape or sexual violence.
[255] A National Consultation on Paediatric HIV/AIDS Treatment Advocacy, held in Durban on 31 January 2005, op cit, p3.

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from the initial visit to the prescription of drugs, and children are generally pushed to the back of the queue at the clinics.[256]

Cases to obtain consent for antiretroviral treatment for children who are orphaned and living with HIV/AIDS are becoming increasingly common. In terms of the Child Care Act where parental consent cannot be obtained, the Minister of Social Development has to consent on behalf of children. In *Ex Parte Nigel Redman N.O,*[257] children with HIV/AIDS who were all orphans below the age of 14, required antiretroviral therapy at a public clinic in Soweto. They lived in informal care settings. They were not placed in legal custody of their informal care-givers and therefore it was not possible to obtain consent for treatment of these children. An urgent application was therefore brought in the Johannesburg High Court to obtain permission from the High Court for the children to receive antiretroviral treatment.[258] By using the provisions of the Child Care Act relating to Ministerial consent in cases where parental consent could not be obtained, several requests were made on behalf of 40 children requiring access to anti-retroviral treatment, to the Minister of Social Development.[259] Although the Minister provided consent on behalf of some of the children, the Aids Law Project (hereafter the ALP) did not succeed in obtaining permission from the Minister for the remainder of the children to receive antiretroviral treatment and therefore filed another urgent application to obtain permission in December 2003. Although permission was granted by the High Court, the whole procedure was time-consuming, thus delaying important lifesaving anti-retroviral treatment. New applications must be brought to obtain consent in each new instance, or new attempts should be made to obtain Ministerial permission. These applications are expensive, and it is impractical and inconvenient to bring these applications in the High Court every time a child without a legal guardian or parent requires HIV treatment.[260]

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[256] Ibid, p3.
[257] Unreported case no.03/14083 Wits Local Division.
[258] Gerntholtz L, Submission on the Children's Bill, Portfolio Committee on Social Development, National Assembly, 27 July 2004, ALP, Centre for Applied Legal Studies (CALS), University of Witwatersrand, p4.
[259] These requests were made by the Aids Law Project.
[260] Gerntholtz L, Submission on the Children's Bill, op cit, p4.

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The question now arises as to who should consent on behalf of unaccompanied or refugee children. Human Rights Watch's research found that it was problematic to obtain consent on behalf of unaccompanied children, or where parents or guardians refused to consent to medical treatment, thus preventing some children from receiving post-rape medical services, including lifesaving PEP.[261] In some cases, consent for testing and treating unaccompanied children under fourteen could be obtained from the medical superintendent or from the police, but there are many cases where unaccompanied children under 12 years old went untreated simply because no one could consent for them to have HIV treatment. As a result they do not receive vital PEP.[262] In situations where parental or guardian consent was unavailable, physicians sought consent for HIV testing on behalf of the child from the police. While police may give proxy consent to children to undergo forensic examinations in certain situations,[263] they do not otherwise have capacity to consent to HIV testing generally and to PEP on behalf of children under fourteen, which are not part of forensic examinations.[264]

Medical practitioners have also encountered problems with the consent procedures in the Child Care Act. The fact that medical practitioners must apply to the Minister of Social Development for consent in terms of section 39(1) of the Act, is highly impractical and cumbersome.[265] Furthermore, consent is not defined in the Child Care Act. Although the Child Care Act forbids unauthorized testing, this practice is still carried out on abandoned babies.[266] The Child Care Act neither distinguishes between nor defines medical treatment and an operation. This lack of clarity as to whether HIV testing constitutes medical treatment has prevented some children from obtaining vital HIV treatment

[261] See "Deadly Delay: South Africa's Efforts to Prevent HIV in Survivors of Sexual Violence, vol.16, No.3(A) (2004), pp.38,42. http://www.hrw.org/reports/2004/southafrica0304/2.htm Date accessed 4 March 2006.
[262] Deadly Delay: South Africa's Efforts to Present HIV in Survivors of Sexual Violence, op cit, p7.
[263] In cases of child sexual violence where a charge has been laid, the police may consent to a medical examination in terms of the Criminal Procedure Act 51 of 1977, as amended by the Criminal Law Amendment Act 4 of 1992 where the child's parent or guardian cannot be traced within a reasonable time, cannot grant consent in time, is a suspect in the offence, unreasonably refuses to give consent, is incompetent to consent, or is deceased.
[264] Deadly Delay: South Africa's Efforts to Present HIV in Survivors of Sexual Violence, op cit, p7.
[265] *Ex Parte Nigel Redman N.O*, op cit, is a case in question.
[266] Barrett C, McKerrow N, Strode A, *Consultative Paper on Children Living with HIV/AIDS*, Prepared for the South African Law Commission, January 1999, p47. http://www.law.wits.ac.za/salc/issue/aids.pdf Date accessed 2 February 2006.

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services.[267] Medical practitioners who work in hospitals frequently encounter problems with obtaining consent for non-emergency procedures from parents or guardians because they either live too far from the hospital or they cannot be contacted telephonically or they may not return to visit the child because of transport costs or lack of transport.[268]

3. Conclusion

Every individual has the right to privacy, dignity, respect, to make their own decisions and to protect themselves from harm done by others.[269] These rights should be protected in all spheres especially when undergoing any type of medical procedure that might infringe the above rights. Informed consent of a person must be obtained before any health care professional can legally administer any treatment or carry out any other medical procedure. This is based on each person's individual right to self-determination and bodily integrity. Decisions about the medical care of a person should thus be made by both the patient and the health care professional.[270]

Although the Committee on the Rights of the Child expresses the view that children and adolescents should have free access to contraceptives and other services, without laying down a minimum age limit and without parental consent, it opens the door for much controversy and debate.[271] On the one hand, pre-teens and young adolescents can have free access to contraception and other services, whilst on the other hand, minimum age laws exist as to when children may legally consent to sexual intercourse.[272] Furthermore,

[267] Gerntholtz L, Submission on the Children's Bill, op cit, p5.
[268] Barrett C, McKerrow N, Strode A, *Consultative Paper on Children Living with HIV/AIDS,* op cit, p47.
[269] HIV/AIDS and the Law, Health and Medical Rights,
http://www.paralegaladvice.org.za/docs/chap12/03.html Date accessed 23 March 2006

[270] *Children and Informed Consent to HIV/AIDS Testing and Treatment in Botswana*, p8 (copy on file with author).
[271] Sloth-Nielsen J, *Of Newborns and Nubiles: Some Critical Challenges to Children's Rights in Africa in the Era of HIV/AIDS*, in *International Journal of Children's Rights* 13, 73 - 85, 2005, p80.
[272] Ibid, p80.

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parents may express the view that their important role of providing support, guidance and advice to their children in the vital stages of transition into adulthood, is totally disregarded because teens may acquire access to contraception without parental consent.[273] However, if one considers the impact of HIV infection on the lives of youth, and especially the survival and development of teenagers and pre-teens, then one has to weigh up whether it would be better to have a South African society of sick HIV positive children who might or might not develop into healthy adults without important medical interventions like contraceptives and anti-retrovirals or, on the other hand, children who do not get parental consent before they visit clinics for contraceptives to help them prevent sexually transmitted diseases and unwanted teenage pregnancies.

The Constitution provides for the protection of bodily integrity, the health needs of individuals and access to health care services. Obtaining consent for anti-retroviral treatment for children is problematic especially if the children are orphans and making application to the Minister of Social Development is often time consuming; delays in obtaining permission in time can often lead to unnecessary loss of life of children. Furthermore, such applications are expensive, impractical and inconvenient. Chapter 5 of this thesis will deal with an in depth discussion on the Children's Bill[274] with specific reference to the changes that were enacted regarding the age of consent to medical treatment.

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[273] Ibid, p80.
[274] B 70 D of 2003.

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Chapter 4

An analysis of the common law and constitutional rights to privacy, dignity and equality.

1. Introduction

Chapter 3 dealt with issues relating to consent as well as the relationship between parents' consent and children's consent. This chapter will deal with the rights to privacy, dignity and equality as being the most important human rights today and these rights are recognized both by international jurisprudence and our Constitution.[275] Both the right to dignity as well as the right to privacy are recognized in our common law as independent personality rights within the concept of *dignitas*.[276] This chapter will commence with the common law position regarding privacy as well as the constitutional position on privacy. It will then discuss the common law and constitutional right to dignity. Lastly, this chapter will discuss the concept of equality prior to the Constitution as well as important changes that were introduced in the Constitution. These fundamental human rights form the cornerstone of democracy and should be respected in a fair and equitable manner. When children access health care services, their rights to privacy, dignity and equality should be valued and children who are HIV positive should be treated in the same way as all other children. They should have the same access to health care as children who are not afflicted by any ailments and infectious diseases.

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1.1 Common law right to privacy

The importance of privacy as an interest requiring legal protection is emphasized by the recognition of the right to privacy as a fundamental right.[277] The common law recognizes the right to privacy as an independent personality right that the courts consider to be part

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[275] Act 108 of 1996.
[276] Neethling J, Potgieter JM, Visser PJ, *Law of Delict*, Fourth edition, Butterworths (Durban), 2001, p 353.
[277] Neethling J, Potgieter JM, Visser PJ, *Right to Privacy,* Chapter 8 in *Law of Personality,* Second edition, 2004, p219.

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of the concept of *dignitas*.[278] At common law, the breach of a person's privacy constitutes an *iniuria.* It occurs when there is an unlawful intrusion on someone's personal privacy or an unlawful disclosure of private facts about a person.[279] Sociologists and psychologists regard privacy as a valuable and advanced aspect of personality.[280] In *Financial Mail v Sage Holdings*[281] the court held that the unlawfulness of a factual infringement of privacy is judged by the contemporary *boni mores* and the general sense of justice of the community as perceived by the court.[282] In *Bernstein v Bester NO*,[283] Ackermann J mentioned in his judgement some examples of breaches of privacy recognized by the common law. They include entry into a private residence, the reading of private documents, listening to private conversations, the shadowing of a person, the disclosure of private facts which have been acquired by a wrongful act of intrusion, disclosure of private facts in breach of a relationship of confidentiality and a doctor informing third parties that his patient had HIV (as in the case of *Jansen van Vuuren v Kruger*).[284] Besides the question of *animus iniuriandi,* one has to determine whether an invasion of the common law right to privacy has taken place, and whether the invasion of privacy was unlawful.

The ambit and scope of the right to privacy has been a problematic question for more than a century. Warren and Brandeis[285] defined the right to privacy as the right to be left alone. They concluded that the right to be left alone is not to be found in the right to property, but rather in the right to personality. More recently, however, Feinberg[286] has expanded on this conclusion by incorporating privacy within the concept of autonomy,

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[278] Currie I, De Waal J, *Privacy,* Chapter 14 in *The Bill of Rights Handbook,* Fifth edition, 2005, p316. *Bernstein v Bester NO* 1996 (2) SA 751 (CC), para 68.
[279] Currie I, De Waal J, *Privacy,* Chapter 14 in *The Bill of Rights Handbook,* op cit, p316.
[280] Warren S, Brandeis L, *The Right to Privacy* in *Harvard Law Review,* 1890 (4) p193. http://www.doj.gov.za/salrc/ipapers/ip24_prj124/ip24_prj124_2003_ch3.pdf. Date accessed 21 April 2006.
[281] 1993 (2) SA 451 (A).
[282] Supra p462 G.
[283] 1996 (2) SA 751 (CC).
[284] 1993 (4) SA 842 (A).
[285] Warren S, Brandeis L, *The Right to Privacy* in *Harvard Law Review* 1890 (4), p193.
[286] Feinberg J, *Autonomy, Sovereignty and Privacy- Moral Ideas in the Constitution?*, 1983 (58) *Notre Dame Law Review,* p445.

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particularly in the right of a person to decide how to live his or her life and especially how to make critical life decisions.[287] The Constitutional Court has adopted this view.[288]

In addition to the constitutional right to privacy,[289] every person has a common law right to privacy.[290] As stated in the introduction, this is recognized as an independent personality right, which the courts have included within the concept of *dignitas.*[291]

Privacy can be defined as follows:

> "Privacy is an individual condition of life characterized by seclusion from publicity. The condition includes all those personal facts which the person himself at the relevant time determines to be excluded from the knowledge of outsiders and in respect of which he evidences a will for privacy."[292]

Inuiria occurs when there is an unlawful intrusion on someone's personal privacy or an unlawful disclosure of private facts about a person. If however, there is a ground of justification (such as statutory authority), then an invasion of privacy is not wrongful.[293]

If a doctor reveals a patient's HIV status, he may use necessity as a defence. All the requirements of the defence of necessity must then be met in order to justify revealing a patient's HIV status. It must however, be shown that the information was divulged to a person who was actually in danger of suffering harm.[294] *Jansen van Vuuren v Kruger*[295] illustrates the above point quite well. This case dealt with disclosure to third parties who were not sexual partners of the person with HIV/AIDS. A general practitioner informed two colleagues about the HIV-positive status of a patient. The patient contended that the

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[287] Davis DM, Steenkamp A, *Privacy*, Chapter 9 in Cheadle MH, Davis DM, Haysom NRL, *South African Constitutional Law, Bill of Rights,* Second edition, 2005, p1.
[288] *Case and Another v Minister of Safety and Security and Others; Curtis v Minister of Safety and Security and Others,* 1996 (5) BCLR 609 (CC) at para 91.
[289] Section 14 of the Constitution. The Constitutional right to privacy will be discussed.
[290] Blackbeard M, *HIV/AIDS: The Right to Privacy v The Right to Life*, 2002 (65) THRHR, p238.
[291] Neethling J, Potgieter JM and Visser PJ, *The Law of Delict*, op cit, p354.
[292] *National Media Ltd and Others v Jooste* 1996 (3) SA 262 (A) at 271.
[293] Currie I, De Waal J, *Privacy,* Chapter 14 in *The Bill of Rights Handbook,* op cit, 317.
[294] Mellows M, *AIDS and Medical Confidentiality*, Juta Business Law, 1995, p59.
[295] 1993 (4) SA 842 (A).

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disclosure of the test result amounted to a breach of the patient's right to privacy and his right of personality. The court held that AIDS is a dangerous condition, but the lethal and incurable nature of AIDS does not detract from the infected person's right to privacy and that a patient can still expect his or her doctor to act in accordance with the ethical standards of the medical profession. It was therefore held that the communication by the practitioner to his colleagues was unreasonable and accordingly unjustified and wrongful.

In conclusion, a breach of a person's right to confidentiality would be tantamount to a breach of a person's common law right to privacy. Persons affected by and infected with HIV/AIDS have a common law right as well as a constitutional right to have their HIV status kept confidential and for it not to be unlawfully disclosed.

1.2 The Constitutional Position

1.2.1 Privacy and the Constitution

The right to privacy is entrenched in section 14 of the Bill of Rights in the Constitution.[296]

Section 14 not only has an impact on the development of the common law action for invasion of privacy.[297] It creates constitutional rights to privacy.[298] In giving content to the general substantive right to privacy, our courts will be guided firstly by common law precedents and secondly by international and foreign jurisprudence.[299] These new constitutional rights to privacy can generally be divided into privacy rights protecting personal autonomy (substantive privacy rights)[300] and privacy rights protecting

[296] Section 14 states that everyone has the right to privacy, which includes the right not to have (a) their person or home searched; (b) their property searched; (c) their possessions seized; or (d) the privacy of their communications infringed.

[297] *C v Minister of Correctional Services*, op cit, p306.

[298] These rights to privacy are not unique to the South African Constitution, The right to privacy has been guaranteed in international documents as the Universal Declaration of Human Rights (article 12), the International Covenant on Civil and Political Rights (article 17); the Convention on the Rights of the Child (article 16).

[299] Currie I, De Waal J, *Privacy,* Chapter 14 in *Bill of Rights Handbook*, op cit, p316.

[300] Du Plessis L & De Ville J, *Personal Rights*, in *Constitutional and Statutory Interpretation,* First edition, 2000, p242.

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information (preventing disclosures and access to information, also known as information privacy rights). Recognition of these new rights may also give rise to new actions for invasion of privacy which will include not only the interests protected by the common law but also a number of important personal interests as against the State.

Our courts have decided a number of cases relating to the powers of search and seizure and whether it is a violation of the right to privacy in the Constitution. In *Investigating Directorate: Serious Economic Offences and Others v Hyundai Motor Distributors (Pty) Ltd and Others: In Re: Hyundai Motor Distributors (Pty) Ltd and Others v Smit NO and Others (*hereafter the *Hyundai* case),[301] the constitutionality of specific provisions of the National Prosecuting Authority Act[302] that authorized the issue of warrants of search and seizure for purposes of a "preparatory investigation", came under scrutiny.[303] Langa J found that search and seizure provisions, in the context of a preparatory investigation, serve an important purpose in the fight against crime and "it is an objective which is sufficiently important to justify the limitation of the right to privacy of an individual in certain circumstances."[304]

In *Director of Public Prosecutions: Cape of Good Hope v Bathgate*[305] the provisions of Proceeds of Crime Act[306] came under the spotlight as curtailing certain fundamental rights. The search of a home or property constitutes a serious inroad into the right to privacy, which is aggravated by the seizure of valuable possessions. The question to be decided by the court was whether the limitation was justified in terms of section 36 of the Constitution.[307] Van Zyl J described the right to privacy as "fundamental, closely related to dignity, and one which is rarely protected in any closed or undemocratic society."

[301] 2000 (10) BCLR 1079 (CC).
[302] 32 of 1998.
[303] Davis DM, Steenkamp A, *Privacy* in *South African Constitutional Law, Bill of Rights,* op cit, p9.
[304] At para 54.
[305] 2000 (2) BCLR 151 (C).
[306] Act 76 of 1996.
[307] Section 36 states that the rights in the Bill of Rights may be limited only in terms of law of general application to the extent that the limitation is reasonable and justifiable in a society based on human dignity, equality and freedom, taking into account (a) the nature of the right; (b) the importance of the purpose of the limitation; (c) the nature and extent of the limitation; (d) the relationship between the limitation and its purpose; and (e) less restrictive means to achieve the purpose.

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However, the purpose of the Proceeds of Crime Act was to assist in fighting the booming crime industry in South Africa, especially where it is drug-related. The limitation of the respondent's rights was necessary to achieve the objects of the Proceeds of Crime Act namely to recover the proceeds of crime and to prevent its usage. The limitations on the respondent's rights to privacy were justified and proportionate to the purpose of the Act.[308]

The right to privacy is characterized as "lying along a continuum where the more a person interrelates with the world the more the right to privacy becomes attenuated."[309] Ackermann J stated:

> "A very high level of protection is given to the individual's intimate personal sphere of life and the maintenance of its basic pre-conditions and there is a final untouchable sphere of human freedom that is beyond the interference from any public authority. So much so that, in regard to most intimate core of privacy, no justifiable limitation thereof can take place. But this most intimate core is narrowly construed. This inviolable core is left behind once an individual enters into relationships with persons outside this closest intimate sphere; the individual's activities then acquire a social dimension and the right of privacy in this context becomes subject to limitation."[310]

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In *Deutschmann NO and Another; Shelton v Commissioner for the South African Revenue Service,*[311] the High Court followed the definition in *Bernstein v Bester*, describing privacy as "an individual's condition of life characterized by seclusion from the public and publicity. This implies an absence of acquaintance with the individual or his personal affairs in this state." This approach was also followed by Langa J[312] and is

[308] Davis DM, Steenkamp A, *Privacy* in *South African Constitutional Law, Bill of Rights,* op cit, p9.
[309] *Bernstein v Bester*, supra, para 77.
[310] Davis DM, Steenkamp A, *Privacy* in *South African Constitutional Law, Bill of Rights,* op cit, p2.
[311] 2000 (6) BCLR 571 (E).
[312] *Investigating Directorate; Serious Economic Offences and Others v Hyundai Motor Distributors (Pty) Ltd and Others* 2000 (10) BCLR 1079 (CC).

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consistent with that of the US Supreme Court.[313] As Langa J pointed out in the *Hyundai* case:

> "[P]rivacy is a right which becomes more intense the closer it moves to the intimate personal sphere of the life of human beings, and less intense as it moves away from that core."[314]

The approach in *Bernstein v Bester* namely, that privacy is based on the right to an unfettered personality[315] has been developed by the Constitutional Court[316] as follows:

> "Privacy recognizes that we all have a right to a sphere of private intimacy and autonomy which allows us to establish and nurture human relationships without interference from the outside community. The way in which we give expression to our sexuality is at the core of this area of private intimacy."

Steytler[317] argues that "legitimate expectations" have resulted in three spheres of privacy: The first relates to the body of a person, the second relates to a "territorial or spatial aspect", and the third occurs in the context of "communication or information transfer." Wacks[318] disagrees with Steytler and finds that "the essence of thought appears as a derivative of other rights." Wacks further states that "it has colonized traditional liberties, become entangled with confidentiality, secrecy, defamation, property and the storage of information."[319] Blaustein[320] is of the view that there is a "single interest" at the core of the right to privacy, namely human dignity. There is substantial support for this proposition. In *Khumalo and Others v Holomisa*[321] O' Regan J distinguished privacy from dignity. She described dignity as "a value that protects the self-worth of the individual as well as the public's estimation of the worth of the individual." The value of

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313 *Katz v United States* (1967) 389 US 347.
314 2000 (10) BCLR 1079 (CC), at para 18.
315 Davis DM, Steenkamp A, *Privacy* in *South African Constitutional Law, Bill of Rights,* op cit, p3.
316 *National Coalition for Gay and Lesbian Equality and Another v Minister of Justice and Others* 1998 (12) BCLR 1517 (CC) at para 32.
317 Steytler N, *Constitutional Criminal Procedure: A Commentary on the Constitution of the Republic of South Africa, 1996,* 1998 at p 83.
318 Wacks R, *The Poverty of Privacy*, 1980 (96) *Law Quarterly Review,*73 at 88.
319 Ibid, at 88.
320 Blaustein EJ, *Privacy as an Aspect of Human Dignity: An Answer to Dean Posser,* 1964 (39) *New York University Law Review,* p962.
321 2002 (8) BCLR 771 (CC) at para 27.

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privacy, connected as it is to dignity, "recognizes that human beings have a right to a sphere of intimacy and autonomy that should be protected from invasion."[322]

Section 14 of the Constitution can be interpreted as having 2 parts. The first part guarantees a general right to privacy, whereas the second part guarantees protection against specific infringements of privacy, e.g. searches and seizures and infringements of the privacy of communications.

Under the Constitution, however, a two stage analysis must be used to justify whether there was a violation of the right to privacy. Firstly, the scope of the right must be assessed to determine whether law or conduct has infringed the right. Secondly, if there was an infringement, it must be established whether it is justifiable under the limitation clause.[323]

Whilst a parent's privacy rights are protected under both the South African common law and the South African Constitution, [324] children are also bearers of privacy rights, as well as common law and constitutional rights to dignity.[325] Children's rights to privacy should be respected when making decisions which affect their health and wellbeing. The question now arises as to what rights to privacy and dignity are afforded to children in terms of the Constitution. The modern emphasis has moved from the notion of parental rights over children to that of parental responsibilities towards children.[326] Children have increasingly been recognized as bearers of their own rights and entitlements, especially the right to a certain degree of self-determination. [327]

Confidential relationships such as the one between doctor and patient should protect the patient's right to privacy.[328] Because the patient is compelled to inform the doctor of

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[322] Ibid, para 27.
[323] Currie I, De Waal J, *Privacy,* Chapter 14 in *The Bill of Rights Handbook,* op cit, p316.
[324] Section 14 of The Constitution Act 108 of 1996.
[325] Section 10 of The Constitution Act 108 of 1996.
[326] Van Heerden B, Cockrell A, Keightley R, *Personal and Proprietary Aspects of the Parental Power* in Boberg's *Law of Persons and the Family*, Second edition, published by Juta & Co, Ltd, 1999, pp683-4.
[327] *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] 1 AC 112.
[328] Blackbeard M, *HIV/AIDS: The Right to Privacy v The Right to Life*, op cit, p238.

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certain facts about himself, a legal duty of confidentiality, as the corollary of the patient's right to privacy, rests on the doctor.[329] The wrongfulness of an infringement of privacy is determined by the *boni mores* test for reasonableness criterion.[330] A doctor must therefore treat all information regarding a patient's health as confidential, thus upholding the individual's right to privacy. In principle, the doctor's general duty concerning confidentiality exists in respect of every third party. In theory, the doctor thus may not inform the spouse and children of the patient (or sexual partners or former sexual partners) that the patient has tested positive for HIV.[331]

The presence of a ground of justification, however, excludes the wrongfulness of an invasion of privacy. The common law duty of confidentiality is therefore not absolute, since there are other interests that may be more important and that may justify or necessitate the violation of a duty of confidentiality.[332] Disclosure may be justified, inter alia, if the remarks are in the public interest, or in cases of necessity.

The court in *Jansen van Vuuren v Kruger*[333] held that the right of the patient to privacy and the doctor's duty of confidentiality are not absolute, but relative. Conflicting interests are weighed up against each other and a doctor may be justified in disclosing his knowledge where his obligations to society weigh more than his obligations to the individual, because the action of injury is one which is *pro publica utilitate exercetur* (is exercised in public interest).[334] One argument in favour of this view is that the doctor may be justified in disclosing his knowledge of the HIV-positive status of his or her patient to a sexual partner or future sexual partner because the doctor's obligation to society to prevent the sexual partner from contracting HIV carries more weight than his obligation to his patient to keep the doctor-patient relationship confidential. The right to life must take precedence over the right to privacy and other rights, since the result of not

[329] Neethling J, *Persoonlikheidsreg*, op cit, pp276-277.
[330] Neethling J, Potgieter JM and Visser PJ, The *Law of Delict*, 2002, p355.
[331] Divulging such information could lead to a claim in delict.
[332] Blackbeard M, *HIV/AIDS: The Right to Privacy v The Right to Life*, op cit, p238.
[333] 1993 (4) SA 842 (A).
[334] Neethling J, *Persoonlikheidsreg*, op cit, p294, footnote 183.

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adhering to the right to life would be death, which is irreversible, whereas an actionable breach of the right to privacy would mean that damages could be claimed.[335]

The question as to whether doctors should tell parents of their children's HIV status has its own pro's and con's. If a parent discloses a child's status to the child himself or herself, it could be advantageous in that the parent and child can develop a healthier relationship between them. Both parent and child may even cope better as the disease progresses. The downside of disclosure of the child's HIV status to the child is that the child may face additional stigmatization and ostracism.

In conclusion, the supremacy of the Constitution does not mean that all previous notions of privacy will be forgotten and fall into disuse. The courts will inevitably keep the existing common law rules which are in harmony with the values of the Constitution.[336] Section 14 of the Constitution will have an impact on the development of the common law action for invasion of privacy. In terms of section 39 of the Constitution, when interpreting the Bill of Rights, the values which underlie an open and democratic society based on human dignity, freedom and equality, should be promoted. This means that an exercise is required similar to that of ascertaining the *boni mores* or legal convictions of the community in the law of delict. It would seem that at present the Constitutional Court is more inclined to develop the common law than to create a separate "constitutional delict." This however does not mean that such a delict may not be developed in the future.[337]

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Personal autonomy privacy rights protect individuals against intrusion in and interference with their private lives. These are better known as substantive privacy rights. Under the

[335] Ibid, p294.

[336] In *Gardner v Whitaker* 1995 920 SA 672, 684 (E) it was pointed out that caution must be exercised when projecting common law principles onto the interpretation of fundamental rights and their limitation: At common law the determination of whether an invasion of privacy has taken place constitutes a single enquiry. Whereas under the Constitution a two-stage approach must be used in deciding the constitutionality of a statute.

[337] McQuoid- Mason *Invasion of Privacy: Common Law v Constitutional Delict- Does it make a Difference?* (2002) *Acta Juridica* 227 at 243-246.

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new Constitution these rights may be infringed only if the state or party seeking to uphold an infringement can satisfy the test set out in the limitation clause.[338]

Children are protected by the Constitution and their rights to privacy and autonomy should be respected and should therefore not be infringed.

2. Common law right to dignity

Roman law did not have clear definitions of concepts like *corpus, dignitas* and *fama.*[339] According to De Wet[340] *dignitas* was not an independent interest of personality (as the case was with *corpus* and *fama*). As mentioned earlier in the thesis, *dignitas* reflected a person's social standing in society. On the other hand, Joubert[341] in his classification of *iniuria* in Roman law regards *dignitas* as an independent personality interest, namely "the peaceful and dignified attitude which the Romans held in such great esteem."[342] Joubert however qualifies his statement by saying that *dignitas* does not represent a single, clearly defined interest of personality such as in the case of *fama* or *corpus,* but should rather be regarded as "a collective term for personality interests or rights which had not yet been clearly identified and described in Roman law."[343] Roman law treated *iniuria* in a "casuistic manner"[344] giving the impression that an ordered system of personality rights did not exist.

The delict *iniuria* of Roman law did not change in Roman-Dutch law.[345] Voet also reflected the "Roman casuistry" of the Digest,[346] thereby justifying that dignity, privacy and feelings (mainly of chastity and piety) may be classified as personality interests

[338] Woolman S, *Limitations,* Chapter 36, in Chaskalson M et al (eds) *Constitutional Law of South Africa,* Fifth edition, 1999, p2.
[339] Neethling J, Potgieter JM and Visser PJ, *The Law of Personality,* op cit, p47.
[340] De Wet JC, Swanepoel HL, *Strafreg*, 1985, pp 245-246.
[341] Joubert WA, *Grondslae van die Persoonlikheidsreg*, 1953, p83.
[342] Neethling J, Potgieter JM and Visser PJ, *The Law of Personality*, op cit, p48.
[343] Ibid, p48.
[344] Joubert WA, *Grondslae van die Persoonlikheidsreg,* op cit, pp 102-3.
[345] Ibid, p108 et seq.
[346] D 47 10.

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falling within the scope of the concept *dignitas*.[347] The common law delict of *iniuria* has not undergone any changes in modern day South Africa. As discussed earlier under the right to privacy, the South African courts have adopted Voet's definition of *iniuria* without change.[348]

Our courts have included the concept of privacy as part of the right to dignity in many cases over the years. In *O' Keeffe v Argus Printing & Publishing Company Ltd,*[349] Watermeyer AJ interpreted *dignitas* so widely so as to include not only a single right of personality, but "all those rights relating to dignity." Although it was not explicitly stated by the court, the right to privacy is included as "one of those rights." In *S v A,*[350] Botha AJ concluded that "the right to privacy is included in the concept of *dignitas*" and that "there can be no doubt that a person's right to privacy is one of … those real rights, those rights *in rem*, related to personality, which every free man is entitled to enjoy."[351] This view unequivocally recognises the right to privacy as an independent personality right.[352]

In the common law, there is no closed list of impairment to dignity.[353] The following (excluding the invasion of privacy) are broad categories of conduct amounting to breach of a person's dignity, namely: insulting words;[354] insulting conduct;[355] interference with parental authority;[356] impairment of individual liberty, such as unlawful arrest and detention, malicious prosecution or instigations of civil proceedings.[357]

In South Africa, common law reputation or *fama*, is considered separate from dignity and is protected by the law of defamation. Dignity, on the other hand, is protected by the

[347] De Groot was one of the Dutch authors who replaced the Roman system and terminology of personality infringements with terms like "infringements against the body, against freedom and against honour." Ranchod B, *Foundations of the South African Law of Defamation,* 1972, p73, footnote 6.
[348] *R v Umfaan* 1908 TS 62 at 66.
[349] 1954 (3) SA 244 (C).
[350] 1971 (2) SA 293 (T).
[351] Neethling J, Potgieter JM and Visser J, *Law of Delict, 2002*, p241.
[352] *Jansen Van Vuuren v Kruger* 1993 (4) SA 842 (A) at 849.
[353] Haysom NRL, *Dignity*, Chapter 5 in Cheadle MH, Davis DM, Haysom NRL, *South African Constitutional Law, Bill of Rights,* Second edition, 2005, p12.
[354] *Mbillini v Minister of Police* 1981 (3) SA 493 (E) and *S v Jana* 1981 (1) SA 671 (T).
[355] *M v N 1981* (3) SA 493 (E) and *Boswell v Union Club of South Africa (Durban)* 1985 (2) SA 162 (D).
[356] *Gordon v Barnard* 1977 (1) SA 887 (C).
[357] Burchell JM, *Principles of Delict*, 1993 at 199-207.

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iniuria action. The incorporation of reputation under the more general heading would cause more than doctrinal confusion.[358]

2.1 Dignity and the Constitution

The right to human dignity is recognized as a fundamental right in section 10 of the Constitution.[359] It is the cornerstone value of the Bill of Rights as a whole, and all the individual rights are based on this value.[360] This section will discuss both the right and the content of dignity as a foundational value in the Constitution, because children's rights to dignity are compromised especially when they face fears of stigma and discrimination against them due to their HIV status.

2.1.1 The right to dignity as a foundational value

The right to dignity is accepted as a foundational value in the Constitution and is recognized both in the text of the Constitution as well as the decisions of the courts.[361] Even before the text of the final Constitution was adopted, the Constitutional Court proclaimed that the right to dignity was the cornerstone of the constitutional entrenchment of fundamental rights. In *S v Makwanyane and Another*,[362] O'Regan J observed that:

> "Respect for dignity of all human beings is particularly important in South Africa. For apartheid was a denial of a common dignity. Black people were refused respect and dignity and thereby the dignity of all South Africans was

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[358] The International jurisprudence is in favour of the separation of reputation and dignity. Secondly, the Constitutional Assembly had to protect the right to "a good name and reputation" and not to leave its possible protection to the protection of the right to dignity.
[359] Section10 reads: Everyone has inherent dignity and the right to have their dignity respected and protected. It should be noted that section 10 is a provision that may not be ordinarily amended except with a majority of 75% of the members of the National Assembly.
See also *Dawood, Shalabi, Thomas v Minister of Home Affairs* 2000 (3) SA 936 (CC) 961-963; *Moseneke v The Master* 2001 (2) SA 18 (CC) 29-30; *Mohamed v President of the Republic of South Africa* 2001 (3) SA 893 (CC).
[360] Chaskalson A, *The Third Bram Fischer Memorial Lecture,* 2000 (16) *SAJHR* 193.
[361] Haysom NRL, *Dignity*, Chapter 5, in *South African Constitutional Law, Bill of Rights,* op cit, p 5.
[362] 1995 (6) BCLR 665 (CC).

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diminished. The new Constitution rejects this past and affirms the equal worth of all South Africans. Thus recognition and protection of human dignity is the touchstone of the new political order and is fundamental to the new Constitution."[363]

She further stated that:

"the importance of dignity as a founding value of the new Constitution cannot be over emphasized. Recognizing a right to dignity is the acknowledgment of the intrinsic worth of human beings; human beings are entitled to be treated as worthy of respect and concern. This right therefore is the foundation of many of the other rights that are specifically entrenched."[364]

Both O'Regan and Chaskalson linked the right to life with the right to dignity and Chaskalson held that by committing ourselves to a society founded on the recognition of human rights, we are required to value these two rights above all others. These views have been repeated in many subsequent decisions.[365]

2.1.2 The content of dignity as a foundational value

Dignity is often seen as a broad, general and imprecise concept. At its broadest, it means that each person should be treated with respect.[366] There are however, three key elements to the right to dignity. Firstly, dignity implies respect for the level of autonomy of the individual.[367] Secondly, dignity implies the right to be protected from conditions or treatment which offends the individual's sense of worth in society.[368] Thirdly, all humans are entitled to be treated with equal respect and equal concern.[369]

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[363] Ibid, at para 329.
[364] Ibid, at para 328.
[365] *National Coalition for Gay and Lesbian Equality v Minister of Home Affairs* 2000 (2) SA 1 (CC); *Prinsloo v Van der Linde and Another* 1997 (6) BCLR 759 (CC) at paras 31-33; *President of the Republic of South Africa and Another v Hugo* 1997 (6) BCLR 708 (CC) at para 41; *Harksen v Lane NO and Others* 1997 (11) BCLR 1489 (CC) at para 50.
[366] Haysom NRL, *Dignity*, Chapter 5, in *South African Constitutional Law, Bill of Rights,* op cit, p 7.
[367] Ackermann J in *Ferreira v Levin NO and Others*1996 (1) BCLR 1 (CC) at para 149.
[368] Haysom NRL, *Dignity*, Chapter 5, in *South African Constitutional Law, Bill of Rights,* op cit, p 7.
[369] Dworkin R, *Freedom's Law: The Moral Reading of the American Constitution,* 1996 at 10.

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Dignity as a foundational value has played a key role in the manner in which rights are found in the Bill of Rights.[370] The Constitutional Court has given the provision further meaning within the context of the Bill of Rights, having regard to the purpose of the right in question. The right to dignity in section 10 of the Constitution includes the right to personality which would, under justifiable circumstances, place a limitation on freedom of expression. As O'Regan J stated in *Louw v 702 Talk Radio*[371]

> "The value of human dignity in our Constitution is not only concerned with an individual's sense of self-worth, but constitutes an affirmation of the worth of human beings shared by all people as well as the individual reputation of each person built on his or her own individual achievements. The value of human dignity in our Constitution therefore values both the personal sense of self-worth as well as the public's estimation of the worth or value of an individual."[372]

The Court is enjoined by section 39(1) of the Constitution to "promote" all the core values when interpreting the Bill of Rights. In conclusion, the right to dignity "harmonizes the pull or reach of contending rights as well as the other core values."[373] By linking dignity considerations closely to an understanding of the values of democracy, freedom and equality, these values are given a meaning and purpose which brings them into harmony.[374] Constitutional case law clearly shows how dignity plays a vital role as a foundational value intimately linked or implicated in the consideration of other rights and as well as being a right itself. It also illustrates the influence of the right when other rights have been the subject of interpretation.[375]

[370] Haysom NRL, *Dignity*, Chapter 5, in *South African Constitutional Law, Bill of Rights,* op cit, p8.
[371] Case Number 2006/04. In this case a 702 Talk Radio presenter was asked if the term "Dutchman" could be used, he in turn replied "We call them 'bonehead'."
[372] O'Regan quoted from *Khumalo v Holomisa* 2002 (5) SA 401 (CC).
[373] Haysom NRL, *Dignity*, Chapter 5, in *South African Constitutional Law, Bill of Rights,* op cit, p9.
[374] Chaskalson A, *The Third Bram Fischer Lecture,* op cit, pp 201-204.
[375] Haysom NRL, *Dignity*, Chapter 5, in *South African Constitutional Law, Bill of Rights,* op cit, p9.

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3. The Concept of Equality prior to the Constitution

South Africa's history of inequality stems from the apartheid era that thrived in a deeply divided society. It is necessary to understand the past before discussing the constitutional commitment to equality.[376] One of the key features of the apartheid era was the extensive, systematic discrimination of black people in the political, social and economic spheres. Under the apartheid regime, the colour of one's skin dictated whether one could vote, which schools one could attend, where one could live, the amenities one could enjoy, whether one could own land and the availability of economic opportunities. These structures reinforced and reiterated racial inequality that dominated South Africa in both economic and social settings.[377] Socio-economic development of the white population was promoted at the expense of less fortunate groups of South African society.[378] The Constitutional Court has aptly summed up the hardship caused to the disadvantaged section of society in *Brink v Kitshoff NO*[379] .

Apartheid

> "systematically discriminated against black people in all aspects of social life. Black people were prevented from becoming owners of property or even residing in areas classified as 'white', which constituted nearly 90 per cent of the land mass of South Africa; senior jobs and access to established schools and universities were denied to them; civic amenities, including transport systems, public parks, libraries and many shops were also closed to black people. Instead, separate and inferior facilities were provided. The deep scars of this appalling programme are still visible in our society."

South Africa's deeply patriarchal society also contributed directly to gender inequality, both in public and private spheres.[380] Women are increasingly subjected to domestic violence, rape and abuse, and women find themselves at the bottom of the socio-

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[376] Albertyn C, *Equality*, Chapter 4 in Cheadle MH, Davis DM, Haysom NRL, *South African Constitutional Law, Bill of Rights,*, Second edition, 2005, p2.

[377] Ibid, p2.

[378] Currie I, De Waal J, *Equality,* Chapter 9 in *The Bill of Rights Handbook,* Fifth edition, 2005, p231.

[379] 1996 (4) SA 197 (CC).

[380] Albertyn C, *Equality*, Chapter 4, *South African Constitutional Law, Bill of Rights,* op cit, p2.

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economic ladder.[381] Racial discrimination has also entrenched inequalities based on religion, language, ethnicity and colour. Widespread stigmatisation, ostracism and discrimination are levelled against people living with HIV/AIDS. It is this historical backdrop that provided the starting point for the constitutional principle of equality, both as a core democratic value and as a right.

3.1 Equality and the Constitution

In order to give effect to section 9 of the Constitution,[382] one has to look at not only formal equality but also substantive equality. Formal equality means "sameness of treatment." The law must treat individuals in like circumstances alike.[383] Substantive equality requires the law "to ensure equality of outcome and is prepared to tolerate disparity of treatment to achieve this goal."[384] Substantive equality looks at the actual social and economic circumstances of people to determine whether the constitutional commitment to equality is upheld.[385] According to the Constitutional Court, we need

> "to develop a concept of unfair discrimination which recognizes that although a society which affords each human being equal treatment on the basis of equal worth and freedom is our goal, we cannot achieve that goal by insisting upon identical treatment in all circumstances before that goal is achieved. Each case, therefore, will require a careful and thorough understanding of the impact of the discriminatory action upon the particular people concerned to determine whether its overall impact is one which furthers the constitutional goal of equality or not. A classification

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[381] Currie I, De Waal J, *Equality,* Chapter 9 in *The Bill of Rights Handbook*, op cit, p232.

[382] Section 9 of the Constitution deals with equality. In terms of section 9(1) everyone is equal before the law and has the right of equal protection and benefit of the law. Section 9(2) states that equality includes the full and equal enjoyment of all rights and freedoms. Section 9(3) states that the State may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth.

[383] Ibid, p232.

[384] Ibid, p232.

[385] Ibid, p233.

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which is unfair in one context may not necessarily be unfair in a different context."[386]

In terms of section 9 (3), no person shall be unfairly discriminated against, either directly or indirectly. Children and persons infected with and affected by HIV/AIDS face discrimination either by their peers, at schools (in the case of children) or by their communities. This is in direct contrast to the constitutional recognition of the right to equality, which is one of the cornerstones of the Bill of Rights.

The right to equality[387] protects against unfair discrimination on the grounds of race, sex, gender, religion, birth, marital status, age, sexual orientation and disability.[388] Although the Constitutional Court has found that people living with HIV are a disadvantaged group, it is still unclear whether HIV status is an unlisted ground or whether it falls within the ground of disability.[389] The Employment Equity Act[390] includes HIV status as a separate ground. The chief reason for this was that people with disabilities (excluding those who are HIV positive) constitute a designated group under the Act, who generally obtain preferential treatment. It was thus decided to have separate grounds for disability and HIV status.[391]

Equality goes hand in hand with recognizing a person as an individual who should be treated with dignity. There are a number of cases decided by the Constitutional Court that emphasized the relationship between equality and dignity and the right to be free of unfair discrimination.[392] In *President of the Republic of South Africa and Another v Hugo*[393] it was stated:

[386] *President of The Republic of South Africa v Hugo* 1997 (4) SA 1 (CC) para 41.
[387] Section 9 of the Constitution.
[388] Webber DW, *Aids and the Law in South Africa: An Overview*, Aspen Law and Business/ Panel Publishers, July 1999, p153. http://www.aspenpub.com Date accessed 4 July 2005.
[389] The Court did not make a finding either way in *Hoffmann v South African Airways* 2000 (11) BCLR 1211 (CC).
[390] Act 55 of 1998.
[391] Albertyn C, *Equality*, Chapter 4, *South African Constitutional Law, Bill of Rights,* op cit, p40.
[392] Ibid, p8.
[393] 1997 (6) BCLR 708 CC.

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"At the heart of the prohibition of unfair discrimination lies a recognition that the purpose of our new constitutional and democratic order is the establishment of a society in which all human beings will be accorded equal dignity and respect regardless of their membership of particular groups. The achievement of such a society in the context of our deeply inegalitarian past will not be easy, but that that is the goal of the Constitution should not be forgotten or overlooked."[394]

The Constitutional Court further entrenched equality as a fundamental right in the following statement:

"Equality, as that concept is enshrined as a fundamental right… means nothing if it does not represent a commitment to recognizing each person's equal worth as a human being, regardless of individual differences. Equality means that our society cannot tolerate legislative distinctions that treat certain people as second-class citizens, that demean them, that treat them as less capable for no good reason, or that otherwise offend fundamental human dignity."[395]

In *Hoffmann v South African Airways*[396] the court ordered the reinstatement of a person whose application for employment as a cabin attendant had been turned down on the basis of his HIV status. This case stated that legitimate commercial requirements cannot hold preference against the greater interests of society in cases of unfair discrimination by the State:

"Legitimate commercial requirements are… an important consideration… However, we must guard against allowing stereotyping and prejudice to creep in under the guise of commercial interests. The greater interests of society require the recognition of the inherent dignity of every human being, and the elimination of all forms of discrimination. Our Constitution protects the weak, the marginalized, the

[394] At p41.
[395] *President of the Republic of South Africa v Hugo*, op cit, pp104-105.
[396] 2001 (1) SA 1 (CC).

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social outcast, and the victims of prejudice and stereotyping. It is only when these groups are protected that we can be secure that our own rights are protected."[397]

In conclusion, those infected with and affected by HIV/AIDS should not be discriminated against and should be treated with dignity and respect and should be afforded equal treatment. Children often find themselves in a position of distinct disadvantage and more so children with HIV/AIDS, who do not always enjoy the same rights as healthy children. International law and the Constitution guarantee children the right to health. Children with HIV/AIDS should receive primary care as a matter of priority on the same basis as healthy children and not just when there is funding left after budgetary allocations in the health sector.

4. Conclusion

The common law and the Constitution protect a person's right to privacy, dignity and equality. The rights to privacy, dignity and equality are regarded as the cornerstone of the Bill of Rights and all other individual rights should therefore be based on these values. These rights become extremely important when one deals with children who are infected with and affected by HIV/AIDS, because these children are at an obvious disadvantage as a result of blatant discrimination and ostracisation that they face on a daily basis. As a result, this affects their dignity and self-esteem when interacting with their friends and peers. Children with HIV/AIDS should not be denied access to medical treatment as this would amount to a violation and infringement of their rights to privacy, dignity and equality.

Furthermore, the right to privacy as spelled out in the Constitution provides for respect of the individual's life.[398] Society therefore has a responsibility towards those who are HIV positive, especially as far as their rights to privacy, dignity and equality are concerned.

[397] At para 34. *Harksen v Lane NO and Others* 1997 (11) BCLR 1489 (CC) was the first case to explain the equality test.
[398] Acheson D, A Caring Society, *World Health,* 1990, p22.

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All infected persons must enjoy the same basic human rights as uninfected persons, and all forms of discrimination against infected persons should be avoided at all costs. South Africa has a well-developed equality jurisprudence which is designed to obliterate systemic disadvantage and inequalities of the past. Yet we still find that children in general and AIDS orphans in particular are discriminated against on the basis of their status, gender and race. Equality and dignity are both substantive rights and fundamental values that underlie the Constitution. The Constitution and equality jurisprudence indicate that the Government has a positive duty to work towards substantive equality. Yet, in South Africa, people living with HIV/AIDS have had to struggle to enforce their right of access to anti-retroviral medication.

Although the Constitutional provisions relating to privacy, dignity and equality are clearly spelled out, they would have very little value if they are not included in municipal laws to improve children's right and access to health care and medical treatment. The value of privacy recognizes that children have a right to autonomy which should be protected from invasion. The right to dignity emphasizes that children should be treated with respect. The right to life is linked with the right to dignity, and in order to give meaning to this, children should be afforded their Constitutional right of attaining the highest possible health care and medical treatment in order to lead healthy lives. These Constitutional rights and principles relating to the care and protection of children are endorsed in the Children's Bill B70 D of 2003 which will be dealt with in Chapter 5.

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Chapter 5

Legislation and Law Reform

1. Introduction

Chapter 4 focused on children's basic fundamental rights to privacy, dignity and equality both in the common law as well as in the Constitution. This chapter will focus on education policies (in regard to which the National Education Policy Act 27 of 1996 and the South African Schools Act 84 of 1996 will be elaborated upon), followed by the Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000. This chapter will then discuss the Child Care Act 74 of 1983 with emphasis on section 39 of the Act. Before the Children's Bill B70 D of 2003 was passed, the law relating to the age of consent to medical treatment was insufficiently developed. Our legal system therefore was in urgent need of law reform to introduce clarity on this important area of our law. This chapter will provide an overview of the recommendations and submissions prior to the passing of the Children's Bill and the changes that were subsequently made in the Children's Bill regarding the age of consent to medical treatment, HIV testing, confidentiality of information on the HIV/AIDS status of children and access to contraceptives.

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1.1 National Education Policy Act 27 of 1996

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Children with HIV/AIDS often experience stigma and discrimination at school. In many cases children react negatively to discrimination and leave school as a result, without any further education. This becomes problematic because, without basic education, children cannot empower themselves, nor can they receive tertiary education or good jobs in order to care for themselves and their families. In general there was no policy in place that protected learners with HIV/AIDS from unfair discrimination at school level prior to 1996.

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Furthermore, because of the rapid spread of HIV/AIDS in the last two decades, a paradigm shift was needed in the response to HIV/AIDS and a comprehensive national policy on HIV/AIDS was urgently required. In respect of law reform and HIV/AIDS, legislators as well as the judiciary relied on the South African Law Reform Commission (SALRC) for recommendations.[399] Consequently, the national policy on HIV/AIDS for learners in public schools, and students and educators in further education and training institutions was formulated.[400] This Act became known as the National Education Policy Act.[401]

National education policy is a national policy on HIV/AIDS for learners and educators on the management of HIV/AIDS in public and is in accordance with the Constitution. It guarantees the right to a basic education, the right not to be unfairly discriminated against and the right to life and bodily integrity, and the right to privacy.[402] Compulsory disclosure of learner's, student's or educator's HIV status to school or institution authorities is not advised.[403] Learners and students with HIV/AIDS should be given the opportunity to lead as full a life as possible and should also receive an education to the maximum of their ability.[404] One of the purposes of education on HIV/AIDS is to prevent the spread of HIV infection as well as to reduce the stigma attached to the epidemic and also to change people's attitudes towards persons with HIV/AIDS. Education should further ensure that learners and students acquire age- and context-related knowledge and

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[399] The first SALC Committee on HIV/AIDS was formed in 1993 to investigate law reform on HIV/AIDS, (now known as the South African Law Reform Commission (SALRC)). Although the SALRC Committee on HIV/AIDS has published three interim reports recommending key legislative reforms, many of these reforms have either not been properly implemented or not implemented at all. (Webber DW, *Aids and the Law in South Africa: An Overview,* Aspen Law and Business/Panel Publishers, 1999, p4). The SALRC, in its third interim report on aspects of the law relating to HIV/AIDS: HIV/AIDS and Discrimination in Schools (1998), recommended that a national policy for HIV/AIDS in schools was required to protect learners with HIV/AIDS from unfair discrimination in the school environment.
[400] Prinsloo J, Beckmann J, *HIV/AIDS and the Learner,* Chapter 19 in Davel CJ, *Introduction to Child Law in South Africa,* First edition, 2000, p328.
[401] Act 27 of 1996.
[402] Section 3 of the National Education Policy Act 27 of 1996.
[403] National Policy on HIV/AIDS for Learners and Educators in Public Schools, and Students and Educators in Further Education and Training Institutions. The Minister of Education published the national policy on HIV/AIDS in terms of section 3(4) of the National Education Policy Act 27 of 1996.
http://education.pwv.gov.za/HIVAIDS_Folder/AIDSPolicy.htm Date accessed 29 September 2005.
[404] National Policy on HIV/AIDS for Learners and Educators in Public Schools, and Students and Educators in Further Education and Training Institutions., op cit, p3.

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skills to protect them from HIV infection.[405] Research has shown that 60% of children 13 years or younger have had 2 or more sexual partners.[406] This is indicative of the high levels of sexually active persons in schools. Educators should therefore provide sexuality education as well as life skills education. Parents should also take the responsibility of educating their children on how to avoid contracting HIV by not engaging in high risk sexual behaviour. Learners should also be educated about their rights to self-determination as well as the reproductive rights and choices that they can make.[407]

As far as HIV testing and the admission of learners to a school is concerned, a number of guidelines have been laid down.[408] No learner or student may be denied admission to or continued attendance at a school or an institution because of his or her HIV status or perceived HIV status.[409] Routine testing of learners, students or educators for evidence of HIV infection is not justified. Furthermore, the testing of learners or students for HIV/AIDS as a prerequisite for admission to, or continued attendance at, school is also prohibited.[410] Regarding disclosure of HIV/AIDS related information and confidentiality, no learner or student (or parent on behalf of a learner or student), or educator, is compelled to disclose his or her HIV/AIDS status to the school or the institution.[411] In the case of voluntary disclosure, it may be in the best interests of the learner or student with HIV/AIDS if a member of staff of the school or institution who is directly involved with the care of the learner or student, is informed of his or her HIV status.[412] Any person to whom any information about the medical condition of a learner, student or educator with HIV/AIDS has been disclosed, must keep this information confidential.[413]

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[405] Ibid, p5.

[406] Pettifor AE, Rees HV, Steffenson A, Hlongwa-Madikizela L, MacFail C, Vermaak K, Kleinsmidt I, *HIV and Sexual Behaviour among South Africans: a national survey of 15-24 year olds*, Johannesburg: Reproductive Health Research Unit, University of the Witwatersrand, 2004.

[407] Prinsloo J, Beckmann J, *HIV/AIDS and the Learner,* Chapter 19 in Davel CJ, *Introduction to Child Law in South Africa* ,op cit, p330.

[408] National Policy on HIV/AIDS for Learners and Educators in Public Schools, and Students and Educators in Further Education and Training Institutions, op cit, p6.

[409] Ibid, p6.

[410] Ibid, p6.

[411] Ibid, p7.

[412] Ibid, p7.

[413] Ibid, p7.

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Learners should not be discriminated against if they are either infected with or affected by HIV/AIDS and they should be afforded the opportunity of obtaining equal educational opportunities and to lead normal lives.

1.2 The South African Schools Act 84 of 1996

The South African Schools Act aims at providing a uniform system for the organization and governance of schools.[414] Section 5(1) prohibits schools from unfairly discriminating against learners in its admission policies. This provision protects children with HIV or those affected by HIV from being excluded from schools.[415] Section 9 of the Act states that learners may only be expelled from school for corrective purposes. Section 9 thus protects children infected by HIV/AIDS against exclusion or expulsion from school simply because they are HIV positive or affected by HIV/AIDS in some way or another.

The Children's Bill[416] provides in section 21(1) that every child has the right to have access to education on the basis of equal opportunities for all. The formulation of section 21 followed international instruments such as the CRC[417] and the African Charter[418] dealing with children's rights to education.[419] The right to education is of vital importance because it enables individuals to develop and realize their full potential. It also empowers individuals because, through education, individuals are able to exercise their enjoyment of other rights.[420] Section 29 of the Constitution states that everyone has the right to a basic education. Although the right to basic education is a socio-economic right, the way it is entrenched in the Constitution is very different from other socio-

[414] Resource Document on the Laws Affecting Children and Youth Infected with HIV/AIDS, p28. www.childrensrightscentre.co.za/legal_audit/Legal_Audit.doc Date accessed 10 March 2006.

[415] As was the case with Nkosi Johnson who was refused admission to a school in Johannesburg when his HIV status was discovered.

[416] B 70D of 2003.

[417] Article 28 (the right to education).

[418] Article 11 which sets out the content of the educational guarantee.

[419] Veriava F, Submission to the Portfolio Committee Hearings on the Children's Bill, Education Law Project, Law and Transformation Programme, July 2004, p5. www.law.wits.ac.za/cals/docs2004/childrensbill.pdf Date accessed 2 February 2006.

[420] Coomans F, *The core content of the right to education,* in Brand D, Russel S, *Exploring the core content of socio-economic rights: South African and International perspectives,* 2002, p160.

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economic rights which are qualified (like housing and health). The State's approach to providing for education is thus also different.[421]

1.3 The Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000

HIV/AIDS is a very highly stigmatized condition in South Africa and people living with HIV/AIDS are continuously discriminated against by society.[422] The Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000 was passed in February 2000 and became fully operational in the second half of 2003.[423] It prohibits unfair discrimination on any listed grounds.[424] This Act is also known as the Equality Act, and it was enacted to give effect to section 9 of the Constitution to prevent and prohibit unfair discrimination and also to protect human dignity in terms of section 10 of the Constitution.[425]

Socio-economic rights in our Bill of Rights require a "commitment to address conditions of poverty and inequality in our society."[426] The right to equality includes "the full and equal enjoyment of all rights and freedoms."[427] Vulnerable and disadvantaged groups should not be unfairly discriminated against in the enjoyment of their constitutional rights, including socio-economic rights.[428] In terms of section 9(2) of the Equality Act, legislative and other measures may be taken to protect individuals who have been

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[421] In the case of *In Re School Education Bill of 1995 (Gauteng)* 1996(4) SA BCLR (CC), the Constitutional Court acknowledged that the State is not only required not to interfere with an individual's enjoyment of the right, but the State is also obliged to provide basic education.

[422] Currie I, De Waal J, *The Bill of Rights Handbook,* op cit, p260.

[423] De Vos P, *The Promotion of Equality and Prevention of Unfair Discrimination Act and socio-economic rights* in *ESR Review,* Vol. 5, No.2, May 2004, p 1.
http://communitylawcentre.org.za/ser/esr2004/2004may_unfair.php Date accessed 3 October 2005.

[424] The prohibited grounds of discrimination include the 16 grounds listed in the Constitution. In terms of section 34(1) of the Act, because of the importance, the impact on society and link to systemic disadvantage and discrimination on the grounds of HIV/AIDS status, nationality, socio-economic status and family status, special consideration must be given to the inclusion of these grounds as prohibited grounds.

[425] Section 9(4) of the Equality Act.

[426] *Soobramoney v Minister of Health, KwaZulu-Natal* 1997 (12) BCLR 1696 (CC), paras 8 and 9.

[427] Liebenberg S, *The New Equality Legislation: Can it Advance Socio-Economic Rights?* in *ESR Review,*Vol.2, No 3, September 2000, p1.
http://www.communitylawcentre.org.za/ser/esr2000/2000sept_equality.php Date accessed 23 April 2006.

[428] Ibid, p2.

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disadvantaged by unfair discrimination, in order to promote the achievement of equality. Poverty and HIV/AIDS are directly linked and threaten the well-being of many children, and not only those children who are orphaned. Poverty very often leads to children having no food to eat, and this has a direct effect on the efficacy of medication that needs to be taken with meals. Limited resources, which have to be stretched for food and health care requirements for sick adults and siblings, add to the plight of impoverished and disadvantaged individuals infected with and affected by HIV/AIDS.

In terms of the equality jurisprudence developed by the Constitutional Court, unfair discrimination does not mean identical treatment in all cases (formal equality). The impact of the discriminatory provision on the complainant will be looked at to determine whether it is in fact unfair.[429] The Equality Act aims to protect disadvantaged groups from unfair discrimination in accessing and enjoying socio-economic rights and to redress systemic socio-economic inequalities.[430] The existence of systemic discrimination and inequalities in all spheres of life should be addressed and taken into account in the application of the Act.[431] Equality is defined to include substantive equality which ensures equal outcomes for disadvantaged groups and not just formal equality.

The Act takes the Constitution a step further by adding five new prohibited grounds of discrimination to the 17 listed grounds in the Constitution, namely, family responsibility, family status, HIV/AIDS status, nationality and socio-economic status.[432] Socio-economic status and HIV/AIDS as prohibited grounds of discrimination are important for challenging inequalities and disadvantage arising from poverty. Poverty is usually the main barrier to people accessing important health care services such as antiretroviral treatment.[433] The inclusion and recognition of these additional grounds of discrimination

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[429] *Harksen v Lane NO and Others* 1997 (11) BCLR 1489 (CC) at paras 50-51; *Brink v Kitshoff NO* 1996 (6) BCLR 752 (CC), para 44. See also Chapter 4 under the discussion on Equality and the Constitution.
[430] Liebenberg S, *The New Equality Legislation: Can it Advance Socio-Economic Rights?,* op cit, p2.
[431] Section 4(2).
[432] Liebenberg S, *The New Equality Legislation: Can it Advance Socio-Economic Rights?,* op cit, p4.
[433] Ibid, p4.

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were as a result of the "overwhelming evidence of the important impact on society and link to systematic disadvantage and discrimination" of these additional grounds.[434]

The Act affirms that equality cannot be achieved through litigation alone, but that "proactive measures are needed to ensure a thorough, systematic review of laws, policies and social practices."[435] The State has an obligation to take measures to develop and implement programmes aimed at promoting equality.[436]

Individuals infected with and affected by HIV/AIDS should enjoy equal opportunities particularly in the health sector and society should move away from discriminating against HIV positive persons so that the inequalities of the past are redressed.

1.4 The Child Care Act 74 of 1983

As pointed out in Chapter 3 in the discussion on the right to bodily integrity, in terms of both the Constitution and our common law,[437] a patient must consent to all forms of medical treatment. A key piece of legislation governing consent to medical treatment is the Child Care Act 74 of 1983. In terms of section 39 of the Act, a child above the age of 14 years may consent to any form of treatment. In the case of children below the age 14 years, the parent or guardian of the child must consent to medical treatment on the child's behalf. Section 39 of the Child Care Act further states that children over the age of 14 but younger than 18 years need the assistance of their parent or guardian when consenting to an operation.[438] Where a child needs medical treatment and the parent or guardian either refuses to give consent, or cannot be found, or is mentally ill, or is dead, then the medical practitioner must approach the Minister of Social Development or a delegate for permission to treat the child.[439]

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[434] Ibid, p4.
[435] Ibid, p6.
[436] The South African Human Rights Commission and the Commission for Gender Equality may request information on measures taken to achieve equality.
[437] See previous chapter for a discussion on the right to privacy in the Constitution and the common law.
[438] Section 39(4).
[439] Section 39(1).

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As far as consent to the performance of an operation is concerned, section 39(4)(a) provides that any person over the age of 18 years is competent to consent, without the assistance of his or her parent or guardian, to the performance of any operation on himself or herself. The issue of teenage mothers was often raised when dealing with consent to the performance of operations. A teenage mother who is 16 years old can consent to the performance of an operation on her child but not on herself, as she, the mother, is below 18. There are no provisions in the Act dealing with this absurd situation. A solution to this problem is found in the manner in which section 39 is interpreted.[440] The provisions of section 39 must be read as declaratory rather than prohibitory. They declare that a person of a certain age is competent to perform certain acts and not that it is prohibited for a person of a certain age to perform certain acts.[441] Section 39 does not provide that a teenage mother below the age of 18 is competent to consent for the performance of an operation on her child but this seems to be the practice because it is not prohibited by section 39. As far as the performance of an operation on the teenage mother who is not over the age of 18 herself is concerned, the teenage mother's parent or guardian must give consent.[442] Section 39(4)(b)[443] as substituted by section 13 of the Child Care Amendment Act[444] was introduced to enable the supply of family planning services to minors without the knowledge or consent of their parents or guardians.[445]

Regarding the giving of consent to medical or surgical procedures, in terms of section 5(3) of the CTOPA,[446] a pregnant minor has the right to decide to terminate her pregnancy without the consent of her parents or guardian. Although she must be advised

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[440]Policy Guidelines for Youth and Adolescent Health, 2001.
www.doh.gov.za/docs/policy/yah/index.html Date accessed 2 May 2006.

[441] Strauss SA, *Doctor, Patient and the Law, A selection of practical issues,* op cit, p174.

[442] Ibid, p174.

[443] See footnote 185 for the wording of section 39(4)(b).

[444] Act 86 of 1991.

[445] Van Heerden B, Cockrell A, Keightley R, *Judicial Interference With The Parental Power; The Protection of Children* in Chapter 18, Boberg's *Law of Persons And The Family,* Second edition, 1999, p639.

[446] Act 92 of 1996.

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to consult her parents or guardian prior to the termination of the pregnancy, termination may not be denied if she chooses not to consult them or should they not agree with her.[447]

The requirements on consent, as set out in the Child Care Act, instead of protecting children orphaned by AIDS, abandoned children or children who are without parental care because of HIV/AIDS, children living with HIV/AIDS and child survivors of sexual violence, actually create serious obstacles to protecting their rights to life and to the highest attainable standard of health under the Constitution and human rights law.[448]

Medical practitioners encountered numerous problems with the consent procedures in the Child Care Act. As *Ex Parte Nigel Redman N.O*[449] showed, there was an urgent need to re-assess the requirement of informed consent and who may give it, especially in light of the escalation of the AIDS pandemic and the growing number of AIDS orphans. It was clear from this case that the definition of who may consent on behalf of children under 14 had to be re-examined in terms of the Child Care Act and that the Children's Bill thus had to introduce changes not only as far as a whole new approach to the definition of care-givers was concerned, but also the age at which children could consent to medical treatment.[450] Consent plays a vital role in empowering children and their care-givers to participate in decisions affecting children's health.[451]

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1.5 The Children's Bill B70 D of 2003

Whilst the Children's Bill is primarily aimed at child protection, it also places emphasis on the core international and constitutional principle that the child's best interests should be the primary consideration in every matter affecting the child. In addition to the best interests principle, the Children's Bill deals with important measures regarding the

[447] Van Heerden B, Cockrell A, Keightley R, *Judicial Interference With The Parental Power; The Protection of Children* in Chapter 18, Boberg's *Law of Persons And The Family,* op cit, p639.
[448] Gerntholtz L, *An overview of some of the key legal developments in HIV/AIDS and the law, 2003* in *The South African Journal of HIV Medicine*, March 2004, p42.
[449] See Chapter 3 for a full discussion on this case.
[450] Gerntholtz L, *HIV testing and treatment, informed consent and AIDS orphans,* op cit, p4.
[451] Gerntholtz L, *An overview of some of the key legal developments in HIV/AIDS and the law*, op cit, p42.

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realization of children's rights to survival, development, participation and non-discrimination.[452] This is a very significant development because the Bill will repeal the Child Care Act which was definitely not written from a child's rights perspective.[453] The Child Care Act was enacted in the apartheid era when South Africa had neither a democracy nor a Bill of Rights. It consequently did not make provision for key principles like equality for children, non-discrimination and the best interests of the child. Furthermore, when the Child Care Act was enacted, the spread of HIV/AIDS was minimal and no provision was made for HIV/AIDS in the Act.

Our law was in urgent need to reform children's health rights and their needs and to include children in decision-making processes affecting their lives.[454] Children should be entitled to the best possible access to health care[455] and the lower age of consent to medical treatment to 12 years contributes greatly to making health care more accessible to all children.[456] The Children's Bill endorses the right of children to have their opinions considered with due weight (article 12 of the CRC), according to their age and capacity, and in any decision that may affect them.[457] The Bill empowers children to actively participate in their own health decisions as long as they are sufficiently mature to understand the benefits and implications of the treatment.[458] The purpose of the "built in protective mechanism" is that it covers only children with sufficient maturity and understanding who have the capacity to consent.[459] There should be a balance between

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[452] Proudlock P and Dutshke M, *Child rights in focus*, Children's Institute, Submission Number 1, on the Children's Rights Chapter of the Children's Bill, 27 July 2004, p2. http://www.uct.ac.za/depts/ci/plr/pdf/Subs/jul04/ci_rights.pdf. Date accessed 10 March 2006.

[453] Jamieson L and Proudlock P, Children's Bill Progress Update: Report on amendments made by the Portfolio Committee on Social Development, Children's Institute, 27 June 2005, p2. http://web.uct.ac.za/depts/ci/pubs/_pdf/general/SA%20Child%20Gauge%202005.pdf Date accessed 10 March 2006.

[454] Jamieson L, from the Children's Institute, in a debate on the Children's Bill on the programme *Judge for Yourself*, hosted by Judge Dennis Davis on E-TV, 16 April 2006.

[455] Submission on Age of Consent to Medical Treatment and Testing to the NCOP & Select Committee by the Children's Rights Centre (CRC), Children in Distress: Network for children affected by AIDS (CINDI) and Alliance for Children's Entitlement to Social Security (ACESS), 4 November 2005, p2. http://web.uct.ac.za/depts/ci/plr/docs/submissiononAgeconsent.doc Date accessed 10 March 2006.

[456] For a detailed discussion on section 129 of the Children's Bill dealing with the age of consent, see infra.

[457] Submission on Age of Consent to Medical Treatment and Testing to the NCOP & Select Committee, by the Children's Rights Centre (CRC), Children in Distress: Network for children affected by AIDS (CINDI) and Alliance for Children's Entitlement to Social Security (ACESS), op cit, p2.

[458] Ibid, p2.

[459] Ibid, p2.

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child participation and empowerment on the one hand, and the protection of children so that they do not make health care decisions without assistance when they are still immature.[460]

The Children's Bill recognizes that the HIV/AIDS pandemic has dramatically changed the environment in which South African children live. The Bill lowered the age of consent to medical treatment to twelve for children sufficiently mature to understand the "benefits, risks, social and other implications of the treatment,"[461] for children under twelve or otherwise incapable of consent, it recommends consent given by the child's parent, care-giver[462] or relative caring for the child.[463] The Bill also expands the options for consent to medical treatment where a parent or guardian unreasonably refuses to give consent or is unavailable. A person who cares for a child, but who does not have parental rights and responsibilities for that child (such as an unrelated, voluntary caregiver) may consent to medical treatment of that child if such consent cannot be reasonably obtained from the child's parent or care-giver.[464] This provision is a welcome inclusion in the Children's Bill and will remove major impediments to medical treatment for children living with HIV/AIDS and child sexual violence survivors.

1.5.1 Recommendations and submissions prior to the passing of the Children's Bill relating to the age of consent to medical treatment

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The South African Law Reform Commission proposed to change the age threshold from 14 to 12 as the age at which children may consent to medical treatment and may have access to contraceptives. After the National Assembly passed the first Children's Bill in

[460] Ibid, p2.
[461] Section 129 (2)(a) of the Children's Bill B70 D of 2003.
[462] Care-givers are defined in the Children's Bill as any person other than a parent or guardian who factually care for a child and includes (a) a foster parent; (b) a person who cares for a child with the implied or express consent of a parent or guardian of the child; (c) a person who cares for a child whilst the child is in temporary safe care; (d) the person at the head of a child and youth care centre where a child has been placed; (e) the person at the head of a shelter; (f) a child and youth care worker who cares for a child who is without appropriate family care in the community; (g) the child at the head of a child-headed household.
[463] Section 129 (4)(a) of the Children's Bill B70 D of 2003.
[464] Section 129(7) of the Children's Bill B70 D of 2003. Under the Bill's provisions, a hospital superintendent may consent to medical treatment in certain emergency situations and on behalf of street children or children in child-headed households.

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June 2005,[465] it was sent to the second house of Parliament, the National Council of Provinces (NCOP), for debate. During the NCOP deliberations, the age of consent for medical treatment as well as access to contraception was the subject of much discussion.[466]

Before the final passing of the Children's Bill [B70D of 2003][467], the NCOP considered raising the age of consent to medical treatment to 14 years following an amendment proposed by the National House of Traditional Leaders.[468] The Department of Social Development and the Children's Bill Steering Committee recommended (on 11 October 2005) that the minimum age of consent to medical treatment be amended from 12 to 14 years, and that the minimum age for access to contraceptives be changed from 12 to 14 years or alternatively 16 years.[469] This recommendation was vehemently opposed[470] because it goes against international law, namely, General Comment No.4,[471] which verifies that children are sexually active at a younger age and should have the power not only to make decisions, but also to participate in decisions concerning their bodily integrity that directly affects their lives.[472] Furthermore, these decisions should be respected[473] and children are "not simply a passive powerless target group to be aided."[474] In one of the largest national surveys amongst children and youth in South Africa,[475] it was found that 8% of sexually experienced youth reported having sex at 14 years or

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[465] Bills that deal with matters that national government has authority over (e.g. the courts) are processed according to the procedure set out in section 75 of the Constitution and are known as "section 75" bills. Section 75 bills are dealt with only by the national Parliament in Cape Town and the National Assembly has a veto power over any amendments proposed by the NCOP. The first Children's Bill that has just been passed is a section 75 bill.

[466] Jamieson L, Proudlock P, Children's Bill Progress Update, 13 March 2006, Children's Institute, University of Cape Town, p8. http://web.uct.ac.za/depts./ci Date accessed 26 April 2006.

[467] The final version of the Children's Bill was passed on 14 December 2005.

[468] Jamieson L, Proudlock P, Children's Bill Progress Update, 13 March 2006, op cit, p8.

[469] Richter M, Aids Law Project (ALP), in a fax sent to Arico Kotze, Committee Secretary of the Select Committee on Social Services, 7 November 2005, p2.
http://web.uct.ac.za/depts/ci/plr/docs/ALP_SubMisFinal%20NCOP%20Nov%2005.doc Date accessed 14 February 2006.

[470] Ibid, p2.

[471] For a discussion on General Comment No.4, see p27 infra.

[472] Ibid, p2.

[473] This is echoed in Article 12 of the CRC as well as Article 3 of the Children's Charter.

[474] UNICEF, WHO, UNESCO, UNAIDS et al, *A Framework for the Protection, Care and Support of Orphans and Vulnerable Children living in a world with HIV and AIDS,* July 2004, p25.

[475] This survey was conducted by the Reproductive Health Research Unit of Wits University in 2004.

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younger.[476] Surprisingly, youth in rural informal areas had sex at an earlier age in comparison to youth living in formal urban areas, and 66% of the women who reported having been pregnant, said that they did not want to be pregnant.[477] Only 54% of youth felt that they could approach their parents or guardians with questions about sex.[478] It can be concluded from the above survey that children are having sex at a younger age, that there are a huge number of unwanted pregnancies and that a large number of teenagers are not comfortable to raise issues about sex with their parents. Consequently, it is important for children as young as 12 to be able to approach health care workers to ask for medical treatment and contraceptives, without necessarily involving their parents or guardians. This would allow children to take responsibility for their own life decisions by using condoms which can mitigate the transmission of HIV/AIDS and also reduce the rate of unwanted pregnancies.[479]

An increase in the age of consent will therefore be against the spirit and purport of General Comment No.4 and may add to the underestimation and undermining of children's decision-making abilities.[480] It may also exacerbate existing problems that children encounter when accessing their rights to health care in terms of section 27(1) (a)[481] and section 28 (1) (c) of the Constitution.[482]

Finally, as far as children in child-headed households are concerned, they do not have parents or guardians to provide consent for medical treatment or contraceptives. The recommendation of increasing the age of consent to 14 may further exacerbate the vulnerability of those children between 12 and 14 who have no parents or guardians. Furthermore, orphaned children should be encouraged and supported in making positive

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[476] Pettifor AE, Rees HV, Steffenson A, Hlongwa-Madikizela L, MacFail C, Vermaak K, Kleinsmidt I, *HIV and Sexual Behaviour among South Africans: a national survey of 15-24 year olds*.

[477] Richter M, Aids Law Project (ALP), in a fax sent to Arico Kotze, Committee Secretary of the Select Committee on Social Services, op cit, p4.

[478] Ibid, p4.

[479] Ibid, p4.

[480] Richter M, Aids Law Project (ALP), in a fax sent to Arico Kotze, Committee Secretary of the Select Committee on Social Services, op cit, p4.

[481] Section 27(1)(a) states that everyone has the right to have access to health care services, including reproductive health care.

[482] Section 28(1) (c) states that everyone has the right to basic nutrition, shelter, basic health care services and social services.

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health and reproductive choices, and increasing the age of consent would definitely contradict more favourable health options.[483]

By increasing the age of consent to 14, the Children's Bill would contradict the CTOPA[484] which allows children of any age to apply for a legal termination of pregnancy without parental consent. However, the termination of pregnancy cannot be refused if the consent of the parents had not been obtained. Furthermore, if the age for medical treatment and contraception was to be increased, a peculiar situation can arise where an 11 year old could decide whether she wants to have an abortion, yet a 13 year old may not consent to treatment or contraception without assistance. In effect, a 12 year old girl may consent to terminate a pregnancy, but will not be allowed to freely have access to contraceptives that could have prevented the pregnancy in the first place. In conclusion, increasing the age of consent of children to medical treatment and to contraceptives would definitely have a negative impact on the access of children to ARVs, as well as family planning and ensuring positive sexual and reproductive health choices.

The South African Law Reform Commission took the above considerations into account and proposed that the current age threshold of 14 should be changed to age 12.[485] Cabinet concurred with the proposed lowering of the age threshold and the Bill tabled in the National Assembly therefore set the age at 12 years. The National Assembly agreed on 12 as the appropriate age at which a child could consent to medical treatment and have access to contraceptives without parental consent.

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[483] Richter M, Aids Law Project (ALP), in a fax sent to Arico Kotze, Committee Secretary of the Select Committee on Social Services, op cit, p9.
[484] Act 92 of 1996.
[485] Jamieson L, Proudlock P, Children's Bill Progress Update, 13 March 2006, op cit, p8.

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1.5.2 The Children's Bill B70 D of 2003

1.5.2.1 Age of consent to medical treatment (section 129)

What is of particular significance is that the Children's Bill consolidates laws relating to the protection and welfare of children. It contains provisions which deal extensively with consent to medical treatment and operations, HIV testing and confidentiality. A very important change that took place in the Children's Bill is that the age for consent to medical treatment has been lowered from 14 to 12.[486] It should be noted that with the lowering of the age of consent from 14 to 12, a doctor giving such medical treatment has to take into account the mental maturity of the child and whether the child is capable of giving consent and capable of understanding the cost and benefit of treatment. The rationale behind this is that children mature at different rates and stages.[487] The Children's Bill actually makes the law more responsive to the individual child by introducing these new standards whereby the maturity of the child has to be taken into account before an individual child is allowed to give consent. Furthermore, one has to look at the relationship between children and their parents and bear in mind that children are holders of their own rights and the rights in the Constitution apply to children as

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[486] Section 129 (2) provides 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. Section 129 (4) provides that the parent, guardian or care giver of a child may, subject to section 31, consent to the medical treatment of the child if the child is- (a) under the age of 12 years; or (b) over that age but is of insufficient maturity or is unable to understand the benefits, risks and social implications of the treatment. Section 129 (6) provides that the superintendent of a hospital or the person in charge of the hospital in the absence of the superintendent may consent to the medical treatment of or a surgical operation on a child if – (a) the treatment or operation is necessary to preserve the life of the child or to save the child from serious or lasting physical injury or disability; and(b) the need for the treatment or operation is so urgent that it cannot be deferred for the purpose of obtaining consent that would otherwise have been required. Section 129 (7) provides that the Minister of Social Development may consent to the medical treatment of or surgical operation on a child, if the parent or guardian of the child- (a) unreasonably refuses to give consent or to assist the child in giving consent; (b) is incapable of giving consent or of assisting the child in giving consent; (c) cannot readily be traced; or (d) is deceased. Section 129 (8) provides that a High Court or Children's Court may consent to the medical treatment of or a surgical operation on a child in all instances where another person that may give consent in terms of this section refuses or is unable to give such consent.

[487] Masutha M, from the Portfolio Committee and Social Development, in a debate on the Children's Bill on the programme *Judge for Yourself*, hosted by Judge Dennis Davis on E-TV, 16 April 2006.

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well.[488] Children under 12 still will need the consent of their parent or care-giver for medical treatment. Children over 12 who are sufficiently mature to understand the risks and benefits can give consent to medical treatment for themselves. Children over 12 years can also consent to a surgical operation, but they must be assisted by their parent or care-giver. Caregivers, and not just parents and guardians, can now give consent for medical treatment for children under 12. However, consent for a surgical operation, in the case of a non-emergency, may only be given by the Minister of Social Development or the High Court, where no parent or guardian is available.

The inclusion of section 129 (6) in the Children's Bill is vitally important, especially in emergency situations and where street children or children in child-headed households are concerned. Often child survivors of sexual violence, especially those that live in rural areas, are brought to hospitals without their parents or care-givers. Because PEP[489] treatment should be administered within 72 hours of a sexual assault, section 129(6) is a vital provision that allows consent to be given by medical practitioners where it cannot reasonably be obtained from a parent or care-giver.[490]

The Children's Bill has done away with the distinction between treatment and operations as was stipulated in the Child Care Act. The Children's Bill now states that a child may consent to his or her own medical treatment if he or she is over 12 years old and is of sufficient maturity to understand the benefits and risks of the treatment. The Children's Bill contains no separate provision dealing with surgical procedures.

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[488] Jamieson L, from the Children's Institute, in a debate on the Children's Bill on the programme *Judge for Yourself*, hosted by Judge Dennis Davis on E-TV, 16 April 2006.
[489] See footnote 254 for an explanation of PEP.
[490] Gerntholtz L, Submission on the Children's Bill, op cit, p7.

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1.5.2.2 HIV testing (section 130)

The Constitution[491] states that every child has a right to basic healthcare services. Previously it was not clear however, what this right to basic healthcare services included and what the State's responsibility was in relation to children infected with HIV/AIDS.[492] The Children's Bill[493] contains important provisions which deal with HIV testing. Section 130 of the Children's Bill includes important provisions on when a child may be tested for HIV.

Section 130 outlines conditions under which a child may be tested for HIV and the procedure for obtaining informed consent. [494] If the child is over the age of 12 or under the age of 12 but of sufficient maturity, the child may consent to HIV testing. Alternatively, consent may be given by the child's care-giver or parent, the superintendent or person in charge of a hospital or a children's court.[495] This provision has direct implications for health workers. Health workers need adequate training and

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[491] Section 28(1)(c)

[492]SALRC, Project 110, Review of the Child Care Act, Report (December 2002) Children's Bill, Chapter 10, The Protection of the Health Rights of Children, p138.
http://web.uct.ac.za/depts/ci/plr/pdf/salrc_rprt_02/pr110chapter10.pdf Date accessed 7 April 2005.

[493]B70 D of 2003.

[494] In terms of the provisions of section 130 (1), no child may be tested for HIV except when- (a) it is in the best interests of the child and consent has been given in terms of subsection(2); or (b) the test is necessary in order to establish whether- (i) a health worker may have contracted HIV due to contact in the course of a medical procedure involving contact with any substance from the child's body that may transmit HIV; or (ii) any other person may have contracted HIV due to contact with any substance from the child's body that may transmit HIV, provided the tests has been authorized by a court. Section 130 (2) provides that consent for a HIV test may be given by- (a) the child, if the child is-
(i) 12 years of age or older; or (ii) under the age of 12 years and is of sufficient maturity to understand the benefits, risks and social implications of such a test; (b) the parent or care-giver, if the child is under the age of 12 years and is not of sufficient maturity to understand the benefits, risks and social implications of such a test; (c) the provincial head of social development, if the child is under the age of 12 years and is not of sufficient maturity to understand the benefits, risks and social implication of such a test; (d) a designated child protection organization arranging the placement of the child, if the child is under the age of 12 and is not of sufficient maturity to understand the benefits, risks and social implications of such a test; (e) the superintendent or person in charge of the hospital, if – (i) the child is under the age 12 years and is not of sufficient maturity to understand the benefits, risks and social implications of such a test; and (ii) the child has no parent or care-giver and there is no designated child protection organization arranging the placement of the child; or (f) a children's court, if-
(i) consent in terms of paragraph (a), (b), (c) and (d) is unreasonably withheld; or (ii) the child or the parent or care-giver of the child is incapable of giving consent.

[495] HIV/AIDS Sector Submission, Joint HIV/AIDS Sector Submission on Section 75 of the Children's Bill [B 70-2003], presented to the Portfolio Committee on Social Development, 27 July 2004, p8.
http://web.uct.ac.za/depts/ci Date accessed 26 April 2006.

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support to be fully equipped to determine a child's capacity to consent to HIV testing.[496] Children who arrive unaccompanied at clinics are likely to experience problems where health care workers might be unwilling to treat these children.[497]

Section 130 of the Children's Bill provides for children of 12 years and older to consent to an HIV test on their own provided they are able to understand the risks and benefits associated with the test. Children under the age of 12 should have "sufficient maturity to understand the benefits, risks and social implications" of an HIV test, thus they may also consent to an HIV test without the assistance of their parents.[498] This would effectively imply that if a 12 year old undergoes an HIV test and he or she tests positive, then he or she will not be able to use ARVs or other medication unless he or she is assisted by his or her parents.[499] This predicament may compel the child to disclose medical information about him or her to third parties if he or she wants to have access to ARVs. However, this contradicts the provisions of section 133 of the Children's Bill which provides for the confidentiality of information on the HIV/AIDS status of children. This inconsistency would be a stumbling block for 12 and 13 year olds to use ARVs and other medical treatment to treat HIV/AIDS and other opportunistic infections coupled with it. This could lead to a negation of the benefits of HIV testing and it may even discourage it.[500]

As far as the best interests of the child are concerned, is HIV testing at the age of 12 in the best interests of the child? It is alleged that HIV/AIDS places a child at risk and if the affected child knows or is aware of his or her status, then the child will be better equipped to deal with his or her illness.[501] Allowing a child to be tested without parental consent is also in the best interests of the child especially in sexual abuse cases. Frequently children

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[496] Ibid, p8.
[497] Giese S, Meintjes H, Croke R, Chamberlain R, *Health and Social Services to address the needs of orphans and other vulnerable children in the context of HIV/AIDS-* Research reports and recommendations, 2003, Children's Institute and National Department of Health, Pretoria, p1.
[498] Section 130(1)(a)(ii).
[499] Richter M, Aids Law Project (ALP), in a fax sent to Arico Kotze, Committee Secretary of the Select Committee on Social Services, op cit, p6.
[500] Ibid, p6.
[501] Mahery P, from the Children's Institute, UCT at a public debate on HIV/AIDS and the best interests of the child, hosted by the AIDS Legal Network held at Community House, Salt River, Cape Town on 15 March 2006. An article on the debate was published by Rohan-Toefy S, in the Muslim Views, Vol.20, No.3, March 2006, p6.

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aged 12 who need to be tested are victims of sexual abuse and in many cases, the abuser is a family member or a family friend. Therefore, it can be argued, that the child is safeguarded by not requiring parental consent.

The question arises whether HIV testing before a child enters the residential child care system is in the best interests of the child. This is not always an easy question to answer. It has been alleged that what may seem to be in the best interests of the carer may not always be in the best interests of the child. Once a child gets tested and the results are positive, the child may become the subject of ridicule.[502] Children who test positive suffer isolation because of the stigma associated with being infected. In contrast, knowing that a child is infected is particularly important for the carer because it prepares the person for caring and supporting the child.[503] Small children and toddlers very often fall and incur open wounds in playgrounds at educares and pre-schools, and come into physical contact with other children, which can ultimately lead to contact with bodily fluids.[504] This can place uninfected children at serious risk of becoming infected, especially when a child's HIV status is not known.

1.5.2.3 Confidentiality of information on HIV/AIDS status of children (section 133)

Section 133 deals with the circumstances under which the status of an HIV positive child may be disclosed.[505] It has been suggested that children need to be informed of their HIV

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[502] Vermeulen I from Nosipho Dimbaza, Child Welfare at a public debate on HIV/AIDS and the best interests of the child, hosted by the AIDS Legal Network held at Community House, Salt River, Cape Town on 15 March 2006. An article on the debate was published by Rohan-Toefy S, in the Muslim Views, Vol.20, No.3, March 2006, p6.
[503] Ibid, p6.
[504] Sloth-Nielsen J, *Of Newborns and Nubiles: Some Critical Challenges to Children's Rights in Africa in the Era of HIV/AIDS*, op cit, p82.
[505] Section 133(2) states that consent to disclose the fact that a child is HIV positive may be given by the child if the child is 12 years of age or older or, if the child is under 12 years of age and the child is of sufficient maturity to understand the benefits, risks and social implications of such a disclosure.
In terms of section 133 (2)(b), the parent or care giver, if the child is under 12 and not of a sufficient maturity to understand the benefits, risks and social implications of such disclosure, may consent to such disclosure. Furthermore in terms of section 132 (2)(d), the superintendent or person in charge of a hospital may disclose a child's HIV status if the child is under 12 and is not of sufficient maturity to understand the benefits, risks and social implications of such disclosure.

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status sooner rather than later during the course of their illness.[506] It has been argued that disclosure of the diagnosis to the child forms "an integral part of providing comprehensive medical care to a child infected by HIV and may impact positively on adherence to medication."[507] Disclosure of diagnosis may help adolescents in preventing high risk sexual behaviour, and it would contribute positively to curbing the spread of HIV/AIDS. There are however, advantages and disadvantages that must be looked at in deciding whether to disclose the child's status. As far as the advantages of disclosing a child's status are concerned, it is alleged that the parent and child will be equipped with better coping mechanisms and provide support to each other especially as the disease progresses. It will also create a closer bond between parent and child, which will result in stronger family ties.[508] Parents will also feel relieved of the burden of keeping the HIV status of the child a secret and the possibility of accidental disclosure. What is of importance to the child is that disclosure not only forms part of good health, but it also shows respect for the child's individual rights, and it empowers the child to participate in his or her health care.[509] On the other hand the disadvantages of disclosure are that it would result in discrimination against infected persons by peers, at schools, in day-care centres and in the community as a whole.[510] Furthermore, parents must not only cope with their children's HIV status, but may at the same time have to cope with their own illness, deteriorating health and imminent death.[511]

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Doctors' opinions on children coming for treatment at surgeries are more or less the same.[512] Most of the children who are patients, are accompanied by their parents even if they are 12 and older. Most of the doctors feel however that these children are not sufficiently mature to understand and appreciate the nature of the treatment.

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[506]Naeem-Shaik A, Gray G, HIV Disclosure in Children, *South African Journal of HIV Medicine*, Vol 19: 8-10, November 2005, p46.
[507] Ibid, p46.
[508] Ibid, p46.
[509] Ibid, p46.
[510] Ibid, p46.
[511] Ibid, p47.
[512] This is the response that I got from doctors from different areas who are in private practice and working at state hospitals, via telephonic discussion during the week of 6-10 March 2006.

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1.5.2.4 Access to contraceptives (section 134)

The age at which children can have access to contraceptives also came up for much deliberation with the NCOP.[513] Barriers that prevent young people from accessing contraceptives should be done away with especially when considering how sexually transmitted diseases and the HIV pandemic are affecting the health and lives of children. Prior to the passing of the Children's Bill, children of 12 still needed their parents' consent before they could access contraceptives. Although parental consent is necessary to protect young children, it is alleged that as children get older, this can create a stumbling block for adolescents and teenagers who are already sexually active and in need of contraceptives.[514] The Children's Bill focused on this urgent issue to address children's health rights and their needs and to include children in decision-making processes affecting their lives. In fact, the Children's Bill introduced the first changes to the Child Care Act in this regard since 1983.[515]

Section 134 provides for access to contraceptives for children over the age of 12, on request and access to other forms of contraceptives without the consent of the parent or care-giver, provided that the child is at least 12 years of age, and has received the necessary medical advice and has undergone the necessary medical examination.[516] These are important provisions which have direct implications for health care workers as well as children. Few health care workers have the capacity to advise children on adequate contraception. Apart from not being properly trained, health care workers are concerned that if they do not advise and counsel, say for example, a 12 year old, that there would be very little or no support for the young person when he or she goes home.[517]

[513] Jamieson L, Proudlock P, Children's Bill Progress Update, 13 March 2006, op cit, p8.
[514] Ibid, p8.
[515] Jamieson L, from the Children's Institute, in a debate on the Children's Bill on the programme *Judge for Yourself*, hosted by Judge Dennis Davis on E-TV, 16 April 2006.
[516] Draft Discussion Paper on the Provisions of the Children's Bill- HIV/AIDS Sector, August, 2003,p6.
[517] Ibid, p6.

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It is to be noted that access to contraceptives to children aged 12 should not be given willy nilly and without any type of screening or examination to determine whether there is a need for it.[518] Access to contraception must be given only after a medical examination has been conducted because contraceptives have their own risks. However, the idea is to acknowledge certain social realities, that children do have sex at a younger age, and are exposed to infections at a younger age and that sexual exploitation is rife and that everything possible should be done to fight against this reality.[519]

All children have a right to freedom of expression and privacy as well as the right to make proper reproductive choices, and the Children's Bill affords additional protection to ensure that children that may be suffering from abuse, are safeguarded because when a medical professional is approached by a child to obtain contraception, then the medical professional must report any finding that they have with respect to a suspicion of abuse.[520]

2. Conclusion

The Children's Bill will, when promulgated, change a host of issues with particular regard to the age of children to consent to medical treatment and access to contraceptives. The Children's Bill contains far more detailed and elaborate provisions regarding the age of consent to medical treatment, HIV testing, confidentiality of information on the HIV status of children and access to contraceptives than the current law. The Children's Bill has addressed concerns around the age at which children may consent to medical treatment and have access to contraceptives by lowering the age from 14 to 12. This is

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[518] In terms of section 134 (1) No person may refuse—*(a)* to sell condoms to a child over the age of 12 years; or*(b)* to provide a child over the age of 12 years with condoms on request where
such condoms are provided or distributed free of charge.(2) Contraceptives other than condoms may be provided to a child on request by the child and without the consent of the parent or care-giver of the child if—*(a)* the child is at least 12 years of age;*(b)* proper medical advice is given to the child; and
(c) 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.(3) A child who obtains condoms, contraceptives or contraceptive advice in terms of this Act is entitled to confidentiality in this respect, subject to section 105.

[519] Masutha M, from the Portfolio Committee and Social Development, in a debate on the Children's Bill on the programme *Judge for Yourself*, hosted by Judge Dennis Davis on E-TV, 16 April 2006.

[520] Ibid.

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more in line with the social dynamics of South African society where children reach puberty at an earlier age and therefore become sexually active at an earlier age.

The issues of children's rights and the balancing of parental rights have become the focus of healthy debate in South Africa. Although the Children's Bill decreased the age of consent to medical treatment and access to contraceptives to 12, there are parents who are not totally convinced that 12 year olds have the maturity to appreciate the nature and implications of such life-altering decisions. Children need to participate in decisions affecting their health, but at the same time, parents care for their children and want to protect them from unscrupulous medical practices and they want to look after their long term interests. Moreover, parents want to have a positive and constructive input in their children's lives and help them to make the right reproductive choices that they will live with for the rest of their lives, and these choices do not necessarily have to start at the age of 12. As far as access to contraceptives are concerned, whilst it is important for sexually active children as young as 12 to obtain contraceptives from health care workers to reduce the rate of unwanted pregnancies, parents are not totally unapproachable and do have the responsibility of educating their children about life skills and positive reproductive choices that they can make.

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Chapter 6

Concluding remarks

Chapter 1 introduced the theme of this thesis.

In Chapter 2, the four key rights of the CRC, namely, the right to non-discrimination (article 2), the best interests of the child (article 3), the right of the child to survival and development (article 6) and the right of the child to participate in decisions affecting him or her (article 12) were discussed. Furthermore, provisions dealing with the child's right to health and health services (article 24) as well as the child's right to privacy (article 16) were highlighted. General Comment No.3 dealing with HIV/AIDS and General Comment No.4, dealing with issues pertaining to adolescent health and development which lay the basis for child participation in health care issues concerning the child, were described and analyzed.

Chapter 2, as set out above, discussed children's rights to participate in decisions affecting them. Child participation however, should be taken a step further. Children should be given the opportunity to participate in making policies that affect them and their input can be quite useful especially when considering how they feel about current policies. As far as public health programs are concerned, children should be actively involved in disseminating information concerning HIV/AIDS and they should freely express their viewpoints. This would serve both as an educational, as well as a health awareness purpose to those infected with and affected by HIV/AIDS. Not only should communities be consulted, but children should also be consulted when HIV/AIDS policies are drafted and when these programs are evaluated and implemented. Furthermore, there should be reform on the public health laws so that they adequately and effectively address public health issues raised by HIV/AIDS. These reforms however, must be consistent with international human rights obligations.

Chapter 3 focused on the development of children's right to consent to medical treatment in the common law. Chapter 3 further explored the relationship between the child's

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consent and parental consent. Chapter 3 addressed the parent-child relationship and children's autonomy rights and rights to self-determination. Chapter 3 dealt with the provisions of the CTOPA which stipulate that no consent other than that of the pregnant women is required for the termination of pregnancy. This effectively means that a girl can consent to an abortion without parental consent. Chapter 3 further dealt with the provisions of the Constitution dealing with bodily and psychological integrity as well as reproductive rights. The issue of consent to obtain anti-retroviral treatment was also extensively dealt with. Children who need of ARV treatment often encounter barriers especially if they are unaccompanied. Sexually abused children experience difficulty in accessing PEP ARV treatment within 72 hours of a sexual assault and they are very often returned to the abusive environment. Government alleges that clinical trials regarding ARVs are not conclusive and that ARVs are very costly. However, if one weighs up the cost of ARVs against the number of years of healthy adult life, then it is definitely worth the money spent on HIV positive individuals and more especially children.

Chapter 4 discussed the common law and constitutional rights to privacy, dignity and equality in so far as they have a bearing on children in the context of HIV/AIDS. These concepts were enshrined in the Constitution to protect children so that they may have equal access to and enjoyment of medical treatment in the health care sector. Children are placed in a position of distinct disadvantage, and more so children with HIV/AIDS. They do not have the same enjoyment of access to health care services as adults and other healthy children have. Our country has a well developed equality jurisprudence which is aimed at removing systemic disadvantage and past inequalities in the context of HIV/AIDS. The Promotion of Equality and Prevention of Unfair Discrimination Act addresses equality issues and prohibits unfair discrimination and protects human dignity. HIV/AIDS and socio-economic rights is now also included as prohibited grounds of discrimination in order to address the inequalities and disadvantage that arose from poverty. Yet we still find that HIV infected children are heavily discriminated against on the basis of their status, gender and race.

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There is still widespread stigmatization, ostracism and discrimination levelled against children living with HIV/AIDS by their peers, and society should therefore move away from such discriminatory behaviour. The provisions relating to privacy, dignity and equality are clearly enshrined in the Constitution, but they would have very little value if they are not included in domestic laws to improve children's right and access to health-care and medical treatment.

Chapter 5 analyzed the important changes to the age of consent to medical treatment and access to contraceptives that were effected in the Children's Bill B70 D of 2003. Children of 12 who are sufficiently mature to understand the risks and benefits of treatment can give consent to medical treatment and have access to contraceptives themselves without parental consent. Access to contraception may, however, be given only after a medical examination has been conducted because contraceptives have their own risks.

An important inclusion in section 129 is that it allows care-givers, and not just parents or guardians, to give consent to medical treatment for children under 12. This is especially important to children with HIV/AIDS who are orphaned and who are cared for by a variety of care-givers. The Children's Bill obviates the need for High Court consent to be obtained in all cases, because of the provisions of section 129 of the Children's Bill, which allows medical practitioners to give consent where it cannot reasonably be obtained from a parent or care-giver in cases of emergency. Section 130 of the Children's Bill provides for children of 12 years and older to consent to an HIV test on their own provided they are able to understand the risks and benefits associated with the test, and they are of sufficient maturity to understand the benefits, risks and social implications of an HIV test. They may thus consent to an HIV test without the assistance of their parents. Section 134 provides that children of age 12 may have access to contraceptives without the consent of the parent or care-giver.

In conclusion, does the Children's Bill adequately address the issues surrounding consent to medical treatment and access to contraceptives? In my submission, the Children's Bill has addressed these issues effectively and adequately for the following reasons. Firstly,

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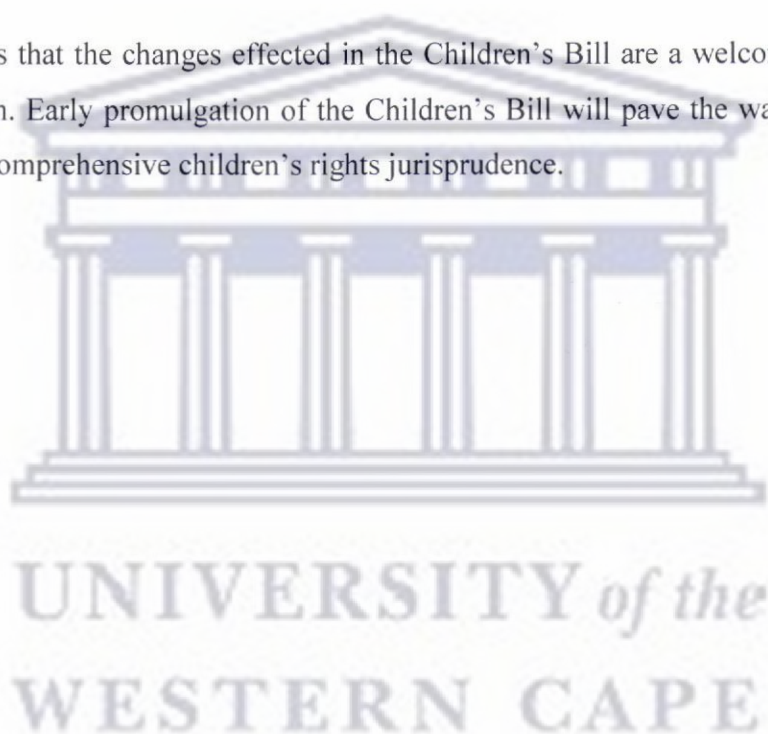
the Children's Bill has addressed concerns around the age at which children may consent to medical treatment and have access to contraceptives by lowering the age from 14 to 12, which appears more closely related to the onset of puberty and sexual activity. Secondly, the Children's Bill now contains far more elaborate provisions in spelling out the need for HIV testing. A child, who is over the age of 12 or under the age of 12 but of sufficient maturity, may consent to HIV testing. Lastly, the Children's Bill obviates the distinction between medical consent and surgical procedures, as the Bill contains no separate provision dealing with surgical procedures.

This thesis argues that the changes effected in the Children's Bill are a welcome step in the right direction. Early promulgation of the Children's Bill will pave the way forward to a much more comprehensive children's rights jurisprudence.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