

CHILDREN'S HEALTH SERVICE RIGHTS AND THE ISSUE OF CONSENT

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KEYWORDS

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Limitations



ABSTRACT

Children's health service rights and the issue of consent

P. S Mahery

Although the concept of human rights is very much accepted as part of human existence throughout the world today there is still much controversy surrounding the idea of rights for children. The Constitution however not only recognises the fact that like all other members of society, children are capable of being bearers of human rights but emphasises also the special position of children in society by granting them specific rights in the Constitution. Health rights are particularly important for children as the entitlements and obligations created by such rights are necessary for children to realise their full potential. In this thesis the entitlements and obligations attached to children's health service rights in the Constitution are explored. The extents to which these rights are respected are also considered with a particular focus on consent laws. Through consent laws children in certain age groups are given decision making powers relating to their health care. A unique relationship exists between the issue of consent and children's right to health care services. This relationship becomes more apparent when one investigates the impact that legislative ages of consent has on those children assumed to be incompetent to consent because they are below the age of consent. In this thesis an impact analysis of consent provisions and the use of ages of consent is undertaken in respect of provisions contained in the Children's Act.

DECLARATION

I declare that *Children's health service rights and the issue of consent* is my own work, that it has not been submitted before for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged as complete references.

Prinslean Sandra Mahery

November 2007

Signed.....



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CHAPTER 1: INTRODUCTION

For centuries children were regarded as being incapable of possessing their own rights. However a worldwide conversion to a culture of respect for human rights gradually saw to it that the rights of children received recognition and acceptance globally. This thesis examines a particularly important right guaranteed in the South African Constitution to everyone including and specifically to children, namely, health as a human right.

In the context of this thesis, the significance of health as a human right in South Africa today is largely due to the history of the health system in the pre-democratic South Africa.¹ This history illustrates the limited and sometimes lack of health entitlements for the majority of South Africans and also the limited responsibilities taken on by the then undemocratic-state in respect of health needs for the larger part of the South African communities.² The need to ‘heal the injustices of the past [in the health system]’³ and to transform it into one based on constitutional values resulted in a shift from past practices and an acknowledgement of the significance of health as a human right. This ‘shift’ and ‘acknowledgment’ is illustrated by the inclusion of health rights in the Final Constitution

¹ This history has been well documented. See for example, J Heaton and E Davie (1991) *South African Human Rights and Labour Law Yearbook* 19 at 19. South Africa’s historical and political context is also outlined in, *In re: Certification of the Constitution of the Republic of South Africa, 1996*, 1996 (10) BCLR 1253 (CC) paras 5 -13. C Ngwenya (2000) *Journal for Juridical Science* 1 at 4-5. See also K Pillay (2003) *Law, Democracy and Development* 55 at 56. J Mubangizi (2002) *TSAR* 343 at 346. S Liebenberg and K Pillay (eds) (2002) *Socio-Economic Rights in South Africa: A Resource Book* 224.

² See L London (2004) *Health and Human Rights* 1 where the author notes ‘Apartheid laws created the homelands system as the cornerstone of ‘separate development,’ depriving black South Africans of citizenship and confining them to underdeveloped and impoverished homelands generating a legacy of death and disease due to undernutrition, tuberculosis, and infantile gastroenteritis, illustrating starkly the impact of human rights violations on health’ at 2-3. See also S Khoza (ed) (2007) *Socio-economic rights in South Africa: a Resource book* at 276.

³ Preamble of the Constitution.

despite strong opposition to the inclusion of socio-economic rights in the Constitution generally.⁴

Given the position that children hold in society, to be able to share in entitlements created by rights as significant as health rights is a great advantage for them in many respects.

⁴ The debates surrounding the inclusion of socio-economic rights were very contentious. Although there was general consensus that civil and political rights had a place in the Interim Constitution there were different opinions about the need for socio-economic rights in the Interim or the Final Constitution. 'On the one hand it was argued that if socio-economic rights were not given meaningful protection by the Constitution then the legitimacy of the Constitution would suffer because people would be bound to say it does not deal with their most fundamental needs. On the other hand it was argued that it would be equally erosive to the legitimacy of the Constitution if it promised too much.' See C Heyns and D Brand (1998) *Law, Democracy and Development* at 153. See also, N Haysom (1992) *South African Journal on Human Rights* 451 where this debate was also explored. Claims were made that socio-economic rights were not justiciable and thus had no place in the Constitution. The main arguments against constitutional protection of socio-economic rights were founded in the distinction made between such rights and civil and political rights. See in this regard again N Haysom at 458-461. This distinction between socio-economic rights and civil and political rights has often been criticised as being false. See B de Villiers (1994) 'Social and economic rights' in D van Wyk, J Dugard, B de Villiers and D Davis (eds) *Rights and constitutionalism: The new South African legal order* 599 at 622-625: The debate on the justiciability of socio-economic rights was put to rest by the Constitutional Court in the *First Certification* judgment (and subsequent judgments) when the Court held that socio economic rights are to some extent justiciable (enforceable) and 'at the very minimum, socio economic rights can be negatively protected from improper invasion'. See *Ex Parte Chairperson of the Constitutional Assembly: In re Certification of the Constitution of the Republic of South Africa 1996*, 1996 4 SA 744 (CC) at para 78. For more on the debates and the drafting history of socio economic rights see generally, J Mubangizi 'The constitutional protection of socio-economic rights in selected African countries: A comparative evaluation' (2006) 1 *African Journal of Legal Studies* 1 at 2. See also B De Villiers at 622-626 and P de Vos (1995) *SAPR/PL* at 236-239 and See S Khoza 'The importance of a dialogue on strategies to promote socio-economic rights in South Africa' *ESR Review* (2006) vol 7 6 at 7.

This thesis explores those advantages created through health rights for children and also looks at challenges emanating from attempts to implement children's health rights. Before an outline of the general content of the chapters is given there are two things which must be mentioned at the outset for the benefit of the reader. The first issue relates to certain aspects relevant to the investigation about to be embarked on which are not considered in this thesis and the second relates to the terminology used throughout the thesis.

1.1 EXCLUSIONS

Although an attempt to explore every single aspect relevant to this investigation could have added a great deal to this thesis a broad and unfocused child rights discussion on the issue would overshadow the main focus of the thesis and run the risk of frustrating rather than enlightening the reader. Thus, some relevant and equally important aspects of the issue of children's health rights are not explored, for example children's health rights in international law⁵ is not particularly focused on but it is equally relevant to this issue. This is so especially given the fact that South Africa has ratified the United Nations Convention on the Rights of the Child⁶ (CRC) as well as the African Charter on the

⁵ The right to health is found in international instruments like Article 12 of The Convention on the Elimination of All Forms of Discrimination against Women, entered into force 3 September 1981, As well as in Article 5 of The International Convention on the Elimination of all forms of Racial Discrimination, entered into force 4 January 1969. For a reference on other international instruments in which the right to health appear see the Committee on Economic, Social and Cultural Rights: General Comment 14 '*The right to the highest attainable standard of health*' at para 2. See also A Chapman (2002) 'Core obligations related to the right to health' in A Chapman and Sage Russel (eds) *Core obligations: building a framework for economic, social and cultural rights* 185 at 191-192. See also P Hunt and J Mesquita (2006) *Human Rights Quarterly* 332 at 341 and A Eide and W Eide 'Comparison with other international human rights provisions' in A Alen *et al* (eds) *Article 24: The right to health: A commentary on the United Nations Convention on the Rights of the Child* 3 2006 Martinus nijhoff Publishers Leiden-Boston.

⁶ Convention on the Rights of the Child (CRC), entered into force 2 September 1990. South Africa ratified the Convention on June 16 1995. Article 24 of the CRC provides:

Rights and Welfare of the Child⁷ where children's health rights are also guaranteed.

Although mention is made particularly of the CRC, it is not focused on given the

-
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.
 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 emphasis on the development of primary health care;
 - (c) To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;
 - (d) To ensure appropriate pre-natal and post-natal health care for mothers;
 - (e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents;
 - (f) To develop preventive health care, guidance for parents and family planning education and services.
 3. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children
 4. States Parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realization of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries.

⁷ African Charter on the Rights and Welfare of the Child, entered into force 29 November 1999. The Charter was ratified by South Africa in January 2000.

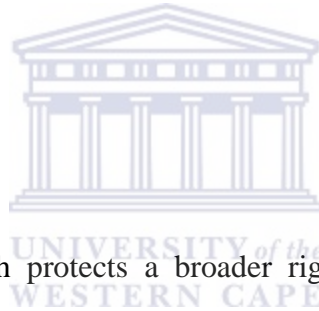
The African Charter on the Welfare of the Child protects children's rights in article 14, which reads:

Article 14:

1. Every child shall have the right to enjoy the best attainable state of physical, mental and spiritual health.
2. States Parties to the present Charter shall undertake to pursue the full implementation of this right and in particular shall take measures:
 - (a) to reduce infant and child mortality rate
 - (b) to ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;
 - (c) to ensure the provision of adequate nutrition and safe drinking water;
 - (d) to combat disease and malnutrition within the framework of primary health care through the application of appropriate technology;
 - (e) to ensure appropriate health care for expectant and nursing mothers;
 - (f) to develop preventive health care and family life education and provision of service;
 - (g) to integrate basic health service programmes in national development plans;
 - (h) to ensure that all sectors of the society, in particular, parents, children, community leaders and community workers are informed and supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of domestic and other accidents;
 - (i) to ensure the meaningful participation of non-governmental organizations, local communities and the beneficiary population in the planning and management of a basic service programme for children;
 - (j) to support through technical and financial means, the mobilization of local community resources in the development of primary health care for children.

particular scope of this which is rather centred around health rights and their implementation nationally.

In investigating the scope and nature of health rights for children the thesis looks particularly at entitlements and obligations created by these rights. In considering obligations attached to these rights the thesis only looks at obligations placed on the State and does not consider for example the horizontal application of these rights and the obligations flowing from that. Although parental responsibilities in respect of their children's rights are mentioned in a general way no particular focus is placed on this issue. Again the reason for these exclusions stem from the particular scope and focus of this thesis.



1.2 TERMINOLOGY

Unlike international law which protects a broader right to health⁸ the constitutional provisions explored in this thesis guarantee rights to health care services only. The right to health extends beyond the boundaries of the right of health care services.⁹ Ngwenya explains that the term 'right to health' is preferred in international law because it is more

⁸Both the International Covenant on Economic, Social and Cultural Rights (ICESCR) which entered into force 3 January 1976 and the CRC protects a right to 'the highest attainable standard of health'. See article 12 of the ICESCR and article 24 of the CRC above note 6. In terms of international law health as a right includes health care, which in turn includes health care services. The ICESCR Committee explains that the right to health must be understood as the 'enjoyment of a variety of facilities, goods, services ... necessary for the realization of the highest attainable standard of health'. See Committee on Economic, Social and Cultural Rights (CESCR): General Comment 14 'The right to the highest attainable standard of health' at para 8. Thus, health care is found to include the entire range of health care services, including preventive health care services, as well as medical care and family planning services. See B Toebe (1999) *The Right to Health as a Human Right in International Law* 248.

⁹G Van Bueren (2005) 'Health' in H Cheadle, D Davis and N Haysom (eds) *South African Constitutional Law: The Bill of Rights* 22-1 at 22-5-6. It is also found that the right to health does not mean a right to good health or the best treatment, it entails that at the very least everyone should have access to primary health care services. See Liebenberg and Pillay above note 1 at 230 as well as Ngwenya above note 1 at 20.

inclusive than ‘right to health care’ or ‘right to health protection’ and has acquired more common usage.¹⁰ He notes however that in South Africa the term ‘right to health care’ is generally preferred.¹¹

Although health service rights viewed collectively with other rights in the Constitution could found a right to health equivalent to that in international law¹² Carstens and Pearmain argue, correctly it is submitted that ‘[u]ltimately, the concept of a right to health in South African law is likely to be of limited value since it is the interaction of the various rights in the Bill of Rights which will determine the outcome of a particular case involving health care services rather than a global consideration of a right to health *per se*’.¹³ This is in line with the view of the Constitutional Court (referred to also as ‘the Court’ throughout this thesis) that rights should be understood within their textual setting having regard to the Bill of Rights and the Constitution as a whole,¹⁴ and that socio-economic rights in particular, must be read together in the setting of the Constitution as a whole.¹⁵

The preferred term used to describe the health provisions to be considered in this thesis to is ‘health service rights’ so as to stay in line with the restrictive formulation of the provisions. Since health services are part of health rights, the term ‘health rights’ will also use to refer to the provisions central to the discussions.

¹⁰ C Ngwena (2005) ‘Rights concerning health’ in D Brand and C Heyns (eds) *Socio-Economic Rights in South Africa* 107 at 107.

¹¹ Above note 10 at 108.

¹² P Carstens and D Pearmain (2007) *Foundational Principles of South African Medical Law* 35.

¹³ Above note 12 at 36.

¹⁴ *Government of the Republic of South Africa and Others v Grootboom and Others* 2001 (1) SA 46 (CC) at para 22.

1.3 SUMMARY OF THE CHAPTERS AND THEIR CONTENT

The three chapters about to follow investigate the nature, scope and content of health service rights for children in a textual and practical manner and do so as follows: Chapter 2 sets out the entitlements and obligations attached to health service rights in the Constitution by considering the interpretation given to the content of these rights. While Chapter 2 is more descriptive in format the last two chapters are more analytical. Chapter 3 is an extension of the investigation of the scope and content of children's health rights conducted in the previous chapter. It takes a particular aspect of health rights and considers how it affects children's ability to access health care services. In this chapter accessibility in relation to the issue of children's consent to health services is explored in light of legislative reform in the form of the Children's Act 38 of 2005. Chapter 3 thus considers the consent provisions in the new Act and explores the consequences it has for children's access to health care services. Chapter 4 takes a particularly contentious issue regarding consent, namely, the age of consent, and embarks on an investigation into the constitutional validity of ages of consent in health care provisions particularly in the Children's Act.

1.4: MAIN ARGUMENTS AND CONCLUSIONS

The Constitution grants health rights to everyone and makes special provision for children's health rights. This is significant for children generally and individually. It means that the Constitution guarantees entitlements to children which flow from these health rights. The state thus has an obligation to ensure that these entitlements are

¹⁵ Above note 14 at para 24.

enjoyed by all children. This obligation is usually fulfilled through the enactment of health legislation. The Children's Act which is particularly important in this thesis also provides health provisions to realise the entitlements which these rights give children.

This thesis aims to explore the meaning of health rights for children and to evaluate one of the methods used to give effect to these, namely, the ability to consent to health care services. In so doing the arguments central to this evaluation is to the effect that one of the most essential entitlements stemming from health service rights for children is the ability to access health care services. Health legislation must therefore ensure that children are able to access health care services. In an attempt to give effect to children's entitlements in terms of their health rights, the legislature uses an approach which impacts significantly on children's health service rights. This approach comes in the form of consent laws. An evaluation of consent provisions in the new Children's Act illustrates the positive and negative impact that consent laws have on children's health rights from a practical point of view.

It is however the evaluation of age limitations in consent laws which produced disturbing findings in respect of the health service rights of certain children. The use of this approach in health provisions such as those found in the Children's Act proved to be an impediment to the ability of children below the age of consent to access health care services independently. In light of the guarantees created by health service rights for children below the age of consent an analysis of this approach leads to a finding that it

unreasonably and unjustifiably limits the right of those children to be able to access health care services.



CHAPTER 2: CHILDREN'S HEALTH SERVICE RIGHTS

2.1: INTRODUCTION

The South African Constitution has been hailed as unique and progressive because it includes a range of socio-economic rights complimented by corresponding duties in respect of such rights.¹ Health service rights form part of the pool of socio-economic rights which attract corresponding obligations. Considering that the international right to health has been described as vague due to a lack of clarity around its entitlements and the duties which it places on the state,² does such a description hold true also for health rights contained in the South African Constitution? This is what this chapter aims to explore to some extent.

What are the entitlement and obligations attached to health rights under the Constitution? An attempt to respond to such a question will necessarily require a broad, in-depth investigation into the scope and content of health rights in South Africa generally. However to stay within the scope of this thesis health service rights will be considered only as far as they apply to children. The investigation is further limited to addressing the question raised above, whether the description of international health rights also applies in the context of children's health rights as set out in the Constitution. To this end the chapter will explore the entitlements and obligations attached to these rights as they apply to children.

¹ C Ngwena (2000) *Journal for Juridical Science* 1 at 21. See also J Mubangizi (2006) *African Journal of Legal Studies* 1 at 2-3. Our Constitution is said to provide arguably the most sophisticated and comprehensive system for the protection of socio-economic rights of all the constitutions of the world today. See C Heyns and D Brand (1998) 2 *Law, Democracy and Development* 153 at 153.

While health rights are found in various sections of the Constitution ³ this chapter is limited to an investigation into the content and interpretation given to ‘health service rights’ found in section 27 and section 28(1)(c) of the Constitution. The chapter is thus set out as follows: As a starting point, Section 2.2 provides summaries of leading cases on socio-economic rights for ease of reference to these cases throughout the chapter (and the thesis as a whole). In pursuing clarity on the entitlements and obligations created by sections 27 and 28(1)(c), Section 2.3 deals with children’s health-rights entitlements created by these sections of the Constitution. Section 2.4 further investigates the obligations created by these provisions and the general obligations attached to health rights in terms of section 7 of the Constitution and finally, Section 2.5 will conclude the chapter.



2.2 SUMMARY OF LEADING CONSTITUTIONAL COURT CASES ON SOCIO-ECONOMIC RIGHTS

No investigation of the scope and nature of health service rights can ever be complete without continuous reference to the jurisprudence on socio-economic rights as developed by the Constitutional Court on various occasions. This is why the Courts’ interpretations of socio-economic rights provisions are set out throughout the chapter (and this thesis

² B Toebes (1999) *Human Rights Quarterly* 661 at 661-662.

³Section 12(2) protects the right to bodily and physical integrity including the right to make decisions concerning reproduction, the right to security in and control over one’s body and the right to consent to being subjected to medical or scientific experiments.

Section 24(a) protects everyone’s right an environment which is not harmful to their health or well-being.

Section 27 (1) (a) protects the right to access health care services including reproductive health care.

Section 27(3) grants a right not to be refused emergency medical treatment.

Section 28(1)(c) protects children’s right to basic health care services.

Section 35(2)(e) provides the right to adequate medical treatment at State expense for detained persons, including prisoners.

generally) as the analyses of the relevant socio-economic rights provisions in these sections continue.

Although the jurisprudence on socio-economic rights is still developing, the Constitutional Court started to lay the foundation for adjudicating on these rights ten years ago already. Many cases have emerged since then, adding to the development of the Court's jurisprudence on socio-economic rights. Not all these cases will be discussed here but the one's that laid the foundation are essential to any discussion on socio-economic rights and these are highlighted below with the intention of continuous reference to them as the chapter proceeds.⁴

2.2.1 Soobramoney v Minister of Health⁵

In this case Mr Soobramoney was denied an order in the High Court directing the Addington Hospital to put him on their dialysis programme. He suffered from chronic renal failure and needed regular renal dialysis to keep him alive. At first he obtained the treatment through private doctors and hospitals but when his funds became depleted he sought the treatment from a state facility. Due to limited resources and on the basis that Mr Soobramoney did not comply with the requirements set by the hospital in order to be placed on its dialysis programme the treatment was refused. After being denied treatment Mr Soobramoney made an urgent application to the Durban High Court to set aside the decision of the hospital. His application failed.

⁴ A general discussion of other cases can be found in S Liebenberg (2004) *ESR Review* 7. M Pieterse (2006) *SAJHR* 473. D Davis (2006) *SAJHR* 301. S Khoza (ed) (2007) *Socio-economic rights in South Africa: A resource book* 1. G Devenish (2007) *THRHR* 84.

On appeal to the Constitutional Court Mr Soobramoney claimed that by refusing him treatment the state had infringed his right to life and his right not to be refused emergency medical treatment. The Court held that the appellants' circumstances did not constitute an emergency as set out in 27(3) and that his claim fell to be determined in terms of section 27(1) and 27(2). After considering the state's available resources the Constitutional Court ultimately found that the appellant did not prove that the state's failure to provide renal dialysis facilities to all patients suffering with chronic renal failure was a breach of their obligations under section 27(2).⁶ The appeal was denied.

2.2.2 Government of RSA v Grootboom⁷

Mrs Grootboom and a group of people who were living in deplorable conditions in the informal settlement in Wallacedene decided to move. They then settled illegally on private land earmarked by the state for low cost housing. They were evicted and left homeless. In an urgent application to the Cape High Court the evictees argued that their right to shelter for their children and their right to housing had been infringed by the state and demanded that the state provide them with interim relief until they could be permanently accommodated. The application was successful. The state appealed to the Constitutional Court. After evaluating the state's housing programme the court found that the state did not meet its obligations under section 26(2) of the Constitution. The state's housing programme failed to provide temporary solutions to those in desperate and urgent need. The appeal failed.

⁵ *Soobramoney v Minister of Health, KwaZulu-Natal* 1997 (12) BCLR 1696 (CC)

⁶ Above note 5 at para 36.

2.2.3 *Minister of Health v Treatment Action Campaign*⁸ (TAC)

In this case the Constitutional Court had to consider the governments' policy on prevention of mother to child transmission (PMTCT) of HIV. The policy was that the drug nevirapine prescribed for PMTCT of HIV infected pregnant women was only made available at certain research sites at state hospitals and doctors not working at these sites were unable to prescribe nevirapine to their HIV positive pregnant patients. This placed in danger the lives of the babies of HIV infected women who did not have access to the research sites. The applicants argued that the right to access health care services and the babies' right to basic health care services were violated by the states policy. The state questioned the efficacy of nevirapine, the capacity to provide the full 'package' of the treatment (which included testing and counselling) and claimed that the research sites were to provide crucial data on which a comprehensive programme would eventually be created and provided. The Constitutional Court found that the states policy on PMTCT was too rigid. The measure which the state took to give effect to the right of access to health care services was found not to be reasonable as required by section 27(2). Government was ordered to remove the restrictions.

2.2.4 *Khosa v Minister of Social Development*⁹

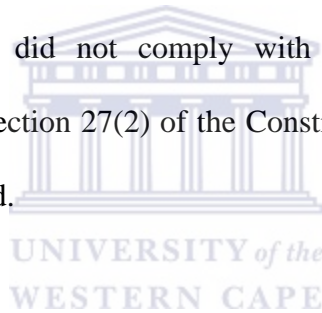
Certain provisions of the Social Assistance Act 59 of 1999 excluded non citizens from being eligible to apply for social assistance. The applicants in this matter were Mozambicans who were permanent residents in South Africa. If they were South African

⁷ *Government of the Republic of South Africa and Others v Grootboom and Others* 2001 (1) SA 46 (CC).

⁸ *Minister of Health and Others v Treatment Action Campaign and Others* (1) 2002 (10) BCLR 1033.

⁹ *Khosa and Others v Minister of Social Development and Others; Mahlaule and Others v Minister of Social Development and Others* 2004 (6) SA 505 (CC).

citizens they would have been eligible for social assistance in terms of the Act. The applicants claimed *inter alia* that the exclusion of non-South Africans from the entitlements under the Social Assistance Act was inconsistent with section 27(1)(c) of the Constitution which guarantees ‘everyone’ the right to social security. It was also contended that the exclusion infringed children’s rights under section 28 of the Constitution. They approached the High Court to declare the provisions unconstitutional and were successful. The order of invalidity had to be confirmed by the Constitutional Court. After considering the principles of the equality clause and the obligations of the state in terms of section 27(2) the Constitutional Court found that the exclusion was discriminatory and could not be saved by section 36 and that the measure of legislative exclusion taken by the state did not comply with the constitutional standard of ‘reasonableness’ as set out in section 27(2) of the Constitution. The relevant parts of the provisions were declared invalid.



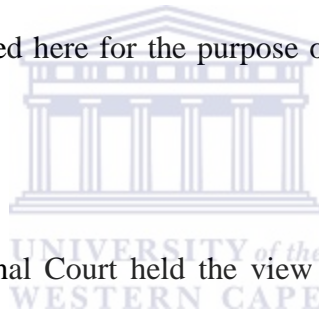
In the section below the provisions containing health rights are analysed by considering the interpretation that the above cases attached to socio-economic rights. It must be noted first that although the interconnectedness of health service rights with other rights is relevant in discussing the interpretation of health service rights, it is not necessary for the purposes of this chapter to launch an inquiry into the interrelatedness of health service rights with other rights, because the interconnectedness of such right and of socio-economic rights is well established¹⁰ (and was confirmed in some of the abovementioned cases).¹¹

¹⁰ See for example P Carstens and D Pearmain (2007) *Foundational Principles of South African Medical Law* 27-34. S Khoza (2007) *Socio-economic rights in South Africa: a resource book* 27. The ‘Vienna

2.3 ENTITLEMENTS CREATED BY HEALTH SERVICE RIGHTS FOR CHILDREN

2.3.1 Separate or additional health rights entitlements for children?

As will be seen from the structure of this section the entitlements for children under section 28 are considered separately from the entitlements created by section 27(1) of the Constitution. The question could then be asked whether children's health rights under section 28 create separate entitlements from those created by section 27. The answer to this question lies in the interpretation of the children's clause and their relation to corresponding clauses which apply to everyone. Although this is discussed more broadly later it must be briefly addressed here for the purpose of explaining the structure of the Section.



In *Grootboom* the Constitutional Court held the view that children's rights in section 28(1)(c) overlap with the rights in section 26 and 27(1) and that this overlap is not consistent with the notion that section 28(1)(c) creates separate and independent rights for children and their parents.¹² In light of this view, Carstens and Pearmain argue, that 'the right of children to basic health care services is therefore a facet of a single right of access to health care services rather than an additional and separate right to the one expressed in section 27(1) of the Constitution'.¹³ This conclusion is in line with the

Declaration and Programme of Action as adopted by the World Conference on Human Rights, Vienna (1993), A/CONF.157/23) also confirms that '[a]ll human rights are universal, indivisible and interdependent and interrelated' at para 5.

¹¹ *Grootboom* above note 7 at para 24 and *Khosa* above note 9 at paras 40-45 .

¹² *Grootboom* above note 7 at para 74.

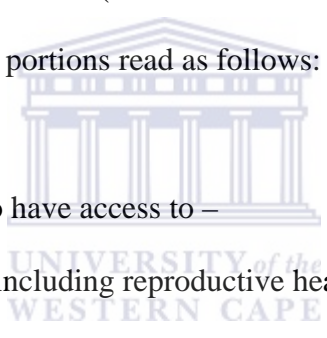
¹³ Carstens and Pearmain above note 10 at 81.

Constitutional Court’s reasoning on the children’s clause. Taking this into account, the reason for not conflating discussions of health service entitlements for children under sections 27(1) and 28(1)(c) is not because of a view favouring arguments that section 28 does in fact create separate and independent rights, but serves rather as a form of structure to the section to indicate different components of the entitlements created by these provisions. The entitlements and obligations as part of the framework of health rights are thus discussed below.

2.3.2 Children’s health services entitlements under section 27

Section 27 guarantees the population (of which children are a part) a right to access health care services. Its relevant portions read as follows:

Health care...

- 
27. (1) Everyone has the right to have access to –
- (a) health care services, including reproductive health care;
.....
 - (2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.
 - (3) No one may be refused emergency medical treatment.

The health-right entitlements stemming from the text of section 27 are found in two subsections. In 27(1) where a right of ‘access to’ health care services, including reproductive health care is guaranteed and subsection 3 which protects the right not be denied emergency services.

2.3.2.1 A right of 'access to'

The right in section 27 is restrictively formulated as a right of 'access to' health care services. So what does the phrase 'a right to access' mean for children and everyone else? What is meant by access to health care services is that there is an adequate supply of health services available, providing right-holders the opportunity to obtain health care when required (i.e. availability) and also that there is actual utilisation of such services.¹⁴ It also means that the 'government must facilitate access to or create an enabling environment for everyone to access a service'.¹⁵ A right of 'access to' however, does not protect a direct and immediate demand for health care services, or imply that such services will be given free of charge.¹⁶

Access to the service also means that the services should also be available without discrimination.¹⁷ Ngwena explains also that '[a] right of access to health care means being able to access health care that is affordable, available, and effective'¹⁸. ...It also means prioritizing care to vulnerable groups, with particular emphasis on women and

¹⁴ M Gulliford *et al* (2003) 'Meaning of "access" in health care' in M Gulliford, and M Morgan (eds) *Access to health care* 1 at 5.

¹⁵ Khoza above note 4 at 34 .

¹⁶ Above note 15. See also C Heyns and D Brand above note 1 at 159 where it is explained that, rights phrased as 'access' rights do not carry with them absolute entitlements to the provision of the social goods in question, free of charge and on demand. See also S Liebenberg and K Pillay (2000) *Socio-Economic Rights in South Africa: A resource book* 27. Ngwena explains further that Section 27 also does not guarantee equal access to health care services in any absolute form or impose an unqualified obligation to provide free health care to all. See Ngwena above note 1 at 3.

¹⁷ C Ngwena and R Cook (2005) 'Rights concerning health' in D Brand and C Heyns (eds) *Socio-Economic Rights in South Africa* 107 at 131.

¹⁸ This interpretation of what 'access to' means in respect of health care services is also supported by the Constitutional Court where it held that government should facilitate access to services by for example making health services affordable or geographically reachable. See *Minister of Health and Another No v New Clicks South Africa (Pty) Ltd and Others (Treatment Action Campaign as amici curiae)* 2006 (2) SA 311 (CC) para 714 at 539A-B. A 2005 revised draft of the Health Charter from the National Department of Health also explained that 'access' means 'having the capacity and means to obtain and use an affordable package of health care services in South Africa in manner that is equitable.' National Department of Health

children.’¹⁹ The state is responsible for facilitating access to the necessary health care services. To sum up, what is gathered from these remarks is that a right ‘of access to’ health services under section 27 does not entitle anyone including children to claim health care services on demand, but it does entitle them to be able to obtain available, affordable and effective health care services such as primary health care services. These claims are subject to limitations as discussed in Section 3.

2.3.2.2 Health care services, including reproductive health care services

Section 27 entitles everyone to access some or the other health care service. The National Department of Health describes ‘health services’ as services which serve the function of responding to health problems as they arise and which play an important role in preventing health problems.²⁰ To enable a better understanding about the type of health services section 27 guarantees it would have been useful if ‘health care services’ was defined in the Constitution, but it is not. The National Health Act 61 of 2003 is the main national legislation aimed at giving effect to the health rights in the Constitution, but it also fails to define health care services. In terms of national policy²¹ health care services

(2005) ‘Revised draft of the Health Charter’ 1 at 7: Available at <http://www.doh.gov.za/docs/misc-f.html> [Accessed 31 October 2007]

¹⁹ C Ngwena (2001-02) *Health and Human Rights* 27 at 31.

²⁰ The National Department of Health (2001) ‘Policy guidelines for Youth and Adolescent health’ Part 3, 18 at 29: Available at <http://www.doh.gov.za/docs/misc-f.html> [Accessed 31 October 2007]

See also Ngwena above note 1 at 20.

²¹ In terms of the White Paper of 1997 the Department of Health adopted the primary health care approach and thereafter introduced a Primary Health Care (PHC) package for South Africa in 2000. This package was introduced as an effective and cost effective approach for promoting the health of all South Africans. The services included in the package consist among others of services ranging from basic personal promotive and preventative services such as family planning to personal curative services for minor ailments like trauma. It includes also maternal and child care services, some other basic services like oral and rehabilitative services and mental health services. National Department of Health (1997) ‘White paper for the transformation of the health system in South Africa’: Available at <http://www.doh.gov.za/docs/legislation-f.html> [Accessed 1 November 2007] See also para 2.6 at Table 3.2 of the Policy for a list of services included in the primary health care package.

include primary health care²² services and these services must be prioritised.²³ Others suggest that health care services ‘include both physical and mental health-care services and the provision of the support in the use of health-related education and information, including education and information on sexual and reproductive health. Such services also include prevention and rehabilitation.’²⁴

Section 27 entitles health rights holders like children the right to access general health care services which basically include primary, secondary and tertiary health services. It also explicitly protects the right to access reproductive health care services.²⁵ By

²² The Alma Ata Declaration on Primary Health Care (1978) defines primary health care as follows ‘[E]ssential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country’s health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process’. See Declaration of Alma-Ata; International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978: Available at http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf [Accessed 1 November 2007].

²³ Ngwena above note 19 at 31.

²⁴ G Van Bueren (2005) ‘Health’ in H Cheadle, D Davis and N Haysom (eds) *South African Constitutional Law: The Bill of Rights* 22-1 at 22-6. The new Children’s Act 38 of 2005 responds to children’s health service rights and contains provisions relating to specific health services available to children such as medical treatment, surgery and HIV testing. See sections 129-134 of the Act. For a discussion of these sections and a description of other legislation giving effect to children’s health rights see Chapter 3 of this thesis. See also S Khoza above note 4 at 289-299.

²⁵ At the Beijing Declaration and Platform for Action, adopted by the 4th World Conference on Women reproductive health was explained as being ‘a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters related to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted

explicitly mentioning reproductive health care section 27 purports to give optimal protection to services of seminal importance to women such as services relating to fertility, pregnancy and other aspects of reproductive health,²⁶ and it serves also to ensure that such services are accessible like any other service.²⁷

2.3.2.3 *Emergency medical treatment*

Medical treatment in whatever form it is provided constitutes a health care service and thus section 27(3) must also be read together with section 27(1).²⁸ Section 27(3) provides that no-one may be refused emergency medical treatment.²⁹ In the *Soobramoney* case the Constitutional Court considered this provision. The Court found that section 27(3) envisioned to address a situation where '[t]he occurrence was sudden, the patient had no opportunity of making arrangements in advance for the treatment that was required, and there was urgency in securing the treatment in order to stabilise his condition. The treatment was available but denied.'³⁰ 'Treatment' for the purposes of this section would include for example ambulance services needed for emergency health care³¹, but would not apply to 'routine preventative, diagnostic and curative treatment'.³² Provision of the

diseases.' See Beijing Declaration and Platform for Action, Fourth World Conference on Women, 15 September 1995, A/CONF.177/20 (1995) and A/CONF.177/20/Add.1 (1995) para 96. Available at <http://www1.umn.edu/humanrts/instreet/e5dplw.htm> [Accessed 1 November 2007]

²⁶ C Chetty (2002) SAPR/PL 453 at 457.

²⁷ Ngwenya above note 1 at 8-9. The reference to such services is particularly significant because such services are essentially accessed by women who, historically, have constituted a vulnerable and disadvantaged class especially in respect of access to abortion. See Ngwenya and Cook above note 17 at 121

²⁸ Van Bueren above note 24 at 22-7.

²⁹ The National Health Act 61 of 2003 also gives effect to this right in section 5 where it states that 'A health care provider, health worker or health establishment may not refuse a person emergency medical treatment'.

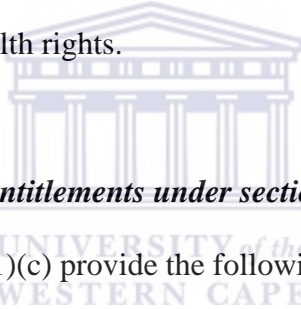
³⁰ *Soobramoney* above note 5 para 18 at 1703E.

³¹ Van Bueren above note 28.

³² M Pieterse (2007) *Stellenbosch Law Review* 75 at 80.

treatment should also not depend on the patients' ability to pay, but this does not mean that it must be provided free of charge.³³

Thus sections 27(1) and (3) entitle children as health right holders to be able to access without discrimination, affordable, available and reachable primary, secondary and tertiary health care services (particularly reproductive services) and to be provided with emergency medical treatment when sudden and unexpected illnesses or injuries befall them. It must be noted also that entitlements in respect of these provisions also appear from the obligations attached to them as set out in section 27(2). This section (discussed further in Section 2.3), entitles everyone to require state measures to be put in place in order to progressively realise health rights.



2.3.3 Children's health service entitlements under section 28(1)(c)

The relevant parts of section 28(1)(c) provide the following

Children

28. (1) Every child has the right –

.....

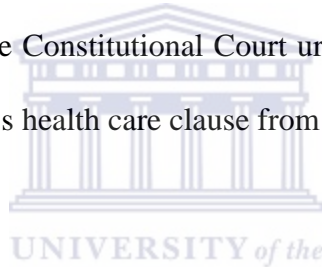
2 to basic nutrition, shelter, *basic health care services* and social services. [Italics inserted]

The entitlements given to children in section 28 (1)(c) can be ascertained from the text of the provision itself. In considering how children's health rights are protected in section 28, the textual difference between sections 28(1)(c) and section 27(1) is hard to miss.³⁴

³³ Above note 32 at 80-81.

2.3.3.1 'Basic' health care services.

Children are only entitled to 'basic' health care services in section 28(1)(c). The word 'basic' indicates the restrictive manner in which the right is formulated.³⁵ Section 27 does not contain this restrictive phrase. The term 'basic health care' is not defined in the Constitution or subsequent legislation or policy and the Constitutional Court has yet to consider its meaning. The need for such a definition is necessary to clarify the entitlements created by the right.³⁶ It has also been suggested that the WHO directives for primary health care could be used as a criteria to define 'basic health care',³⁷ but keeping in mind that 'basic health care' services entitles the right holder to more than what is currently available under the primary health care package of the Department of Health.³⁸ It is submitted that the Constitutional Court urgently needs to give meaning to this term to relieve the children's health care clause from its textual vagueness.



³⁴ The Constitutional Court has yet to address this textual difference. See M Shung-King et al (2004) 'Children's rights to health' in E Coetzee and J Streak (eds) *Monitoring child socio-economic rights in South Africa: achievements and challenges* 127 at 135.

³⁵ I Currie and J de Waal J (2005) *The Bill of Rights Handbook* 612.

³⁶ The need for a definition has also been found necessary for the following reasons: 'Firstly, it would enable children and their caregivers to know what services they are entitled to under the Constitution. Secondly, it would provide service providers, managers and policy-makers with clear goals to work towards. Thirdly, it would allow a more coherent development of laws, policies, programmes, services and budgets by aligning all these to the defined requirements... Lastly, it would enable us to monitor progress made towards the implementation of children's rights to health and health care through the development of appropriate indicators'. See M Shung-King (2005) 'Defining basic health care services for children' Children's Institute Newsletter: Child Rights in Focus. June 2005. Available at http://ci.org.za/depts/ci/eneews/June2005/health_care.htm [Accessed 9 November 2007].

³⁷ See E de Wet (1996) *The constitutional enforceability of economic and social rights: The meaning of the German constitutional model for South Africa* 107.

The six important directives are:

- (1) adequate access to clean drinking water;
- (2) adequate access to sanitation facilities and refuse removal;
- (3) vaccination against diseases such as measles, polio, tuberculosis etc
- (4) access to trained medical staff for the treatment of common diseases and injuries with a regular supply of essential medicines, within one hour's walking or traveling distance;
- (5) access to trained medical staff during pregnancy and birth and;
- (6) after birth.

2.3.3.2 Entitlement to an immediately enforceable right?

Section 28 contains no qualifications of progressive realisation and available resources as found in section 27(2). This has stirred arguments that these limitations do not apply to the rights of children and that children's rights are immediately demandable.³⁹ However others have disagreed, claiming that such an interpretation is unlikely since 'a right cannot place a duty on a state to do what is practically impossible'.⁴⁰ In the *Grootboom* case the applicants claimed that their right to adequate housing in section 26⁴¹ was violated as well as their children's right to shelter as guaranteed in section 28. They claimed that although section 26 had internal limitations, the rights of their children to shelter did not have such a limitation and therefore the right to shelter was immediately enforceable. This implied, that parents through guarantees granted to their children could claim housing on demand. Although the High Court accepted the arguments and found that the children's right to basic shelter was violated by the state, the Constitutional Court found differently. The Constitutional Court rejected these arguments on the ground that it would create an 'anomalous result', in that '[pe]ople who have children [would] have a direct enforceable right to housing in terms of section 28, while others who have no children would not be entitled to housing under the section even though they may be old

³⁸ Shung-King *et al* above note 34 at 136.

³⁹ See *Grootboom* above note 7 para 70-79. See also C Heyns and D Brand above note 1 at 161.

⁴⁰ See Shung-King *et al* above note 34 at 138.

⁴¹ Section 26 reads as follows:

Housing

26.

- (1) Everyone has the right to have access to adequate housing.
- (2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of this right.
- (3) No one may be evicted from their home, or have their home demolished, without an order of court made after considering the relevant circumstances. No legislation may permit arbitrary evictions.

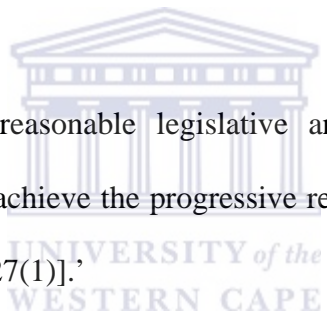
or disabled'.⁴² The Court further found that the rights set out in section 28 overlapped with those found in 26 indicating that section 28 does not create separate and independent rights for children and their parents.⁴³ In respect of health care services the Court's interpretation implies that children are not entitled to claim health care services from the state on demand. This interpretation by the Court also determines the state's obligations in respect of section 28; this is discussed in Section 2.4 below.

2.4 STATE OBLIGATIONS IN RESPECT OF HEALTH SERVICE RIGHTS

Obligations in respect of section 27 and section 28

Section 27(2) provides the following:

'The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights [i.e the rights set out in 27(1)].'



There are three legs to the obligations in section 27(2). First, the state must take reasonable legislative and other measures to give effect to the right. Second, the state has to progressively provide access to health care services and third, the measures which the state takes to progressively realise the right of access to health care services should be done within available resources.

⁴² *Grootboom* above note 7 at para 71.

⁴³ Above note 7 at para 74.

There is no equivalent obligations provision in respect of the rights contained in section 28. So do these three legs of obligations apply to children's health service rights in section 28(1)(c)? The Constitutional Court gave answers to this question.

With regards to the state's obligation to take legislative and other measures to fulfil the rights, the Court in *Grootboom* held in respect of section 28 that

'the state must provide the legal and administrative infrastructure necessary to ensure that children are accorded the protection contemplated by section 28. This obligation would normally be fulfilled by passing laws and creating enforcement mechanisms for the maintenance of children, their protection from maltreatment, abuse, neglect or degradation and the prevention of other forms of abuse of children mentioned in section 28'⁴⁴[reference omitted].

From the above it is clear that the state also has an obligation to take reasonable legislative and other measures to give effect to children's rights to basis health care services as set out in section 28(1)(c).

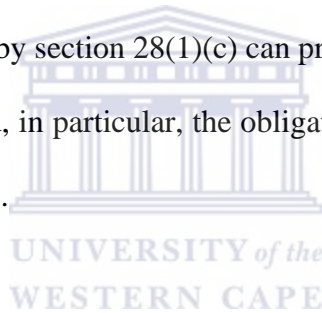
The applicants in *Grootboom* claimed that because the qualifications of progressive realisation and available resources are absent from section 28 it implied that children had an immediately enforceable right to claim shelter on demand from the state. In rejecting this line of argument the Court held that

⁴⁴ Above note 7 at para 78.

‘The carefully constructed constitutional scheme for progressive realisation of socio-economic rights would make little sense if it could be trumped in every case by the rights of children to get shelter from the state on demand.’⁴⁵

This indicates that the second leg of the section 27(2) obligations on the State also applies to rights in section 28(1)(c). Besides the Courts reasoning about the overlap of the rights in section 27 and section 28 at para 74 of its judgment, the fact that the above two legs and the third leg of state obligations, namely, available resources, all apply to children rights in section 28, is confirmed again in the following passage of the judgment;

‘the obligations created by section 28(1)(c) can properly be ascertained only in the context of the rights and, in particular, the obligations created by ss 25(5), 26 and 27 of the Constitution’⁴⁶.



Thus, having established that these three legs of state obligations also apply to children’s rights in section 28⁴⁷ what remains now is to explore the meaning and content of these obligations in respect of children’s health service rights.

2.4.1 Legislative and other measures

In most instances legislation⁴⁸ is required for the full implementation of rights contained in the Constitution. However legislation on its own is not enough to comply with section

⁴⁵ Above note 7 at para 71

⁴⁶ Above note 7 at para 74

⁴⁷ See also D Horsten and L Jansen van Rensburg (2004) *Speculum Juris* 121 at 135.

⁴⁸ This includes subordinate legislation like regulations. See *New Clicks judgment* above note 18.

27(2) or international standards to fulfil socio-economic rights.⁴⁹ In *Grootboom* the Court stated that '[l]egislative measures will invariably have to be supported by appropriate, well-directed policies, and programmes implemented by the executive'.⁵⁰

The form and content of the measure is a choice for the legislature and the executive, but the measure must be designed to meet the obligations placed on the state and must be capable of realising the right it is aimed to realise.⁵¹ It is also not important whether there are other better measures which the state could have adopted, what is essential is that the measure which the state chose to adopt is reasonable.⁵²

2.4.2 Reasonableness review

As seen above, section 27(2) obligates the State to take 'reasonable' legislative and other measures to realise the right of access to health care services. In *Grootboom* the Constitutional Court was invited to determine a minimum core⁵³ in the context of the

⁴⁹ Other measures considered to be appropriate to fulfill socio-economic rights under the International Covenant on Economic and Social Rights (ICESCR) are the provision of judicial remedies, administrative, financial, educational and social measures. See, Committee on Economic Social and Cultural Rights (CESCR) General Comment 3 at para 3. See also para's 5 and 7 of General Comment No. 3. The Committee on the Rights of the Child encourages and identifies appropriate measures of implementation children's rights including legislation and also the development of special structures, the establishment of coordinating and monitoring bodies, comprehensive data collection, awareness raising and training and the development of appropriate policies, services and programmes. See Committee on the Rights of the Child General Comment No.5 at para 1 and 9. See also World Health Organization (2002) '25 Questions and Answers of Health and Human Rights' Health and Human Rights Publication Series at p 16.

⁵⁰ *Grootboom* above note 7 at para 42.

⁵¹ Above note 7 at para 41 .

⁵² Above note 51.

⁵³ The minimum core approach was introduced by the ICESCR Committee in General No 3 at para 10 which provides: '...The Committee is of the view that a minimum core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights is incumbent upon every State party'. This approach operates for the benefit of the most vulnerable in society and it 'identifies a minimum level below which government action should not fall'. See Committee on the Rights of the Child: General Comment No. 3 at para 12. For a discussion of the minimum core approach in international law see also S Khoza (2006) *ESR Review* 2 at 5; S Rosa and M Dutschke (2006) *SAJHR* 224 at 238-240; B Toebe (1999) *The right to health as a human right in international law* 276; A Chapman and S Russel (2002)

right to access adequate housing so as to ‘describe the minimum expected of a state’⁵⁴ in order to comply with its obligations in terms of this right. In declining this invitation the Court noted that the ‘real question’ to be addressed was whether the measures taken by the state to realise this right were reasonable.⁵⁵ This was the inception of the reasonableness approach which the Court has since its introduction in *Grootboom* placed at the centre of its interpretation of socio-economic rights cases. The Court did however find that minimum core obligations could be taken into account in determining the reasonableness of measures taken by the state.⁵⁶

The rejection of the minimum core approach by the Constitutional Court has triggered different responses from academics, some have criticised this move⁵⁷ others argue that it was a wise one to make,⁵⁸ and while others continue to find use for this approach despite rejection by the Constitutional Court⁵⁹ others debate the Courts decision by contrasting

Core Obligations: Building a Framework for Economic, Social and Cultural Rights 1 at 8-10; See also in that same book A Chapman ‘Core obligations related to the right to health’ 185-215 where Chapman discusses the minimum core obligations relating to health rights in international law.

⁵⁴ I Rautenbach (2005) *TSAR* 627 at 645.

⁵⁵ *Grootboom* above note 7 at para 33.

⁵⁶ Above note 55.

⁵⁷ D Chirwa (2003) *East African Journal of Peace & Human Rights* 174 at 187-188. S Liebenberg ‘The interpretation of socio-economic rights’ in S Woolman, R Klaaren, A Stein and M Chaskelson (eds) *Constitutional Law of South Africa* 33-i at 33-30-31. D Horsten and L Jansen van Rensburg above note 47 at 136. D Bilchitz (2003) *SAJHR* 19 1 at 12-18. Bilchitz criticise even the limited role the Constitutional Court gave to the minimum core approach by making it part of the reasonableness enquiry. He argues that this approach is incorrect and that ‘the minimum core does not gloss the notion of reasonableness; rather, reasonableness is assessed in terms of whether a government has complied with its minimum core obligations in terms of the right.’ He argues that separate enquiries are undertaken for determining the reasonableness of a measure introduced by the state and the analysis of minimum core obligations which considers the obligations created by the right and the notion of progressive realisation. These two enquiries should thus not be conflated according to Bilchitz.

⁵⁸ M Wesson (2004) *SAJHR* 284 at 303-305.

⁵⁹ See Rosa and Dutschke above note 53 at 239 where the authors argue that the minimum core approach (and other international standards) should be used by the South African Courts when dealing with children’s socio-economic. They note that ‘In relation to children, when assessing if the minimum core has been met, the court must apply the general principles of the UNCRC and the APCRWC [African Charter]. The court must therefore scrutinise whether due priority has been given to vulnerable groups of children,

the minimum core approach to the reasonableness approach.⁶⁰ It is submitted that however intriguing these academic discussions are ‘no amount of jurisprudential gnashing of analytical teeth or academic concern about the failure to follow comparative international law’⁶¹ will change the Courts decision to reject the minimum core approach in favour of the reasonableness review. In light of this rejection it is submitted that a broad discussion on the debates surrounding the minimum core approach would not add much to the discussion at hand and will thus not be undertaken. The reasonableness approach is central to the courts socio-economic rights jurisprudence and a discussion on this is thus continued below.

In the *Grootboom*, *TAC* and *Khosa* cases, the Constitutional Court had to consider the reasonableness of the policies, programmes and legislation that the state put into operation in order to give effect to the rights in section 26 and 27 respectively. On all occasions, it was held that the measures taken by government failed to comply with the test of reasonableness. In *Grootboom* where the Court considered the states’ housing programmes it held that ‘ [a] programme that excludes a significant segment of society cannot be said to be reasonable’⁶². Furthermore, ‘[t]hose whose needs are the most urgent and whose ability to enjoy all rights therefore is most in peril, must not be ignored by the measures aimed at achieving realization...If the measures, though statistically successful,

that the best interests of children are protected, that the level of the minimum core is such that it ‘facilitates the survival and development of the child and, finally, that the child’s views have been respected in the process’. See also Khoza above note 52 at 4-5 where the author argues in favour of a principled minimum core for health.

⁶⁰Liebenberg above note 57 at 33:30. Rosa and Dutschke argue that the Court’s use of the reasonableness review achieves a similar effect to the sentiments behind the minimum core. Rosa and Dutschke above note 53 at 256. Devenish notes that the Court has implicitly recognised a minimum core right in *Grootboom* and *TAC*. Devenish above note 4 at 105.

⁶¹ D Davis (2006) *SAJHR* 301 at 304.

fail to respond to the needs of those most desperate, they may not pass the test'.⁶³ In sum the Court's tests the reasonableness of a program introduced by the state to fulfil its constitutional obligations by looking at whether the program is "comprehensive", 'coherent', 'balanced' and 'flexible'⁶⁴ and it must not exclude a significant sector of society particularly those whose needs are most urgent.⁶⁵ In this case the state's housing programme failed because it did not give even temporary relief to people who were living in 'intolerable conditions or crisis situations'.⁶⁶ In *TAC*, the Court had to consider government policy on prevention of mother to child transmission (PMTCT) of HIV. The policy was that the drug nevirapine prescribed for PMTCT of HIV infected pregnant women was only made available at certain research sites at state hospitals and doctors not working at these sites were unable to prescribe nevirapine to their HIV positive pregnant patients. This placed in danger the lives of the babies of HIV infected women who did not have access to the research sites. In this case the government's measure under section 27(2) failed and was found unreasonable because it 'exclud[ed] those who could reasonably be included where such treatment is medically indicated to combat mother to child transmission of HIV'.⁶⁷

In *Khosa*, provisions of the Social Assistance Act which excluded permanent residents from obtaining social assistance were found unconstitutional and in breach of section 27(2) because the provisions unjustifiably excluded a particular vulnerable group of

⁶² *Grootboom* above note 7 at para 43.

⁶³ Above note 62.

⁶⁴ *Wesson* above note 58 at 287.

⁶⁵ Above note 58 at 288.

⁶⁶ Above note 62.

⁶⁷ *TAC* above note 8 at para 125.

society. The Court held that '[w]hen the rights to life, dignity and equality are implicated in cases dealing with socio-economic rights, they have to be taken into account along with the availability of human and financial resources in determining whether the State has complied with the constitutional standard of reasonableness'.⁶⁸ After considering the purpose of the exclusion and the impact it had on the life and dignity of the complainants, the Court in *Khosa* held that the denial of access to social services to permanent residents was not a reasonable legislative measure as required by section 27(2) of the Constitution.⁶⁹ The paragraphs in these judgments indicate the criterion created by the Constitutional Court by which to test reasonableness of the measure the state chooses to put in place in order to comply with its obligations under section 27(2) of the Constitution.⁷⁰



⁶⁸ *Khosa* above note 9 para 44 at 528E.

⁶⁹ Above note 9 para 82 at 540A-B.

⁷⁰ Bilchitz provides a useful summary of the specific features of reasonableness based on the Constitutional Court's interpretation in 11 points:

'A reasonable programme must allocate responsibilities and tasks to the different spheres of government.

1. A reasonable programme must allocate responsibilities and tasks to the different spheres of government.
2. It must ensure that the appropriate financial and human resources are available.
3. The programme must be capable of facilitating the realization of the right in question.
4. A wide range of possible measures can be reasonable. The question is not whether other measures are more desirable or favourable. (This criterion seems to indicate a difference between reasonableness in the context of socio-economic rights and reasonableness in the context of the limitations clause; the limitation clause requires that the measures adopted be the least restrictive means in violating a right and realising an important social purpose).
5. The measure must be reasonable 'both in their conception and their implementation'.
6. A reasonable programme must be balanced and flexible.
7. A reasonable programme must attend to 'crises': a reasonable programme must 'respond to the urgent needs of those in desperate situations'.
8. A reasonable programme must not exclude 'a significant segment' of the affected population.
9. A reasonable programme must balance short, medium and long-term needs.
10. A reasonable programme does not render the best the enemy of the good: it is not necessary to design the ideal programme prior to its initial implementation. For instance, in *TAC*, waiting for the best programme to be developed for a protracted period of time before deciding to extend the use of nevirapine beyond the research sites was not reasonable given the benefits that could be achieved by rolling out the drug in the interim.]
11. A reasonable programme will not discriminate unlawfully between persons on grounds which have a serious impact upon dignity.'

Since the Court introduced the reasonableness test there has been lots of academic opinion on the issue which generally indicate the positive and negative impact that this approach has on the enjoyment of socio-economic rights.⁷¹ It is submitted that however compelling the positive influence of the approach to socio-economic rights may be, the mere fact that it has the potential to negatively impact on the enjoyment of socio-economic rights -by for example not creating any sense of urgency for the state to fulfil its obligations in respect of socio-economic rights⁷² or by creating difficulties for the enforcement of socio-economic rights by individuals and group living in poverty,⁷³ or that the way this approach operates create problems for the delivery of entitlements stemming from court orders,-⁷⁴ can never be good for the advancement of such rights.

2.4.3 Progressive Realisation

The State has to progressively realise the right to access health care services. In the context of health care, progressive realisation as explained by the Court in *Grootboom*

See D Bilchitz (2007) 'Health' in S Woolman, T Roux and M Bishop (eds) *Constitutional law of South Africa, Student Edition* 56A-i at 56A-12. For more summaries of the reasonableness test: See also Chirwa above note 57 at 184. See also Liebenberg above note 57 at 33:34.

⁷¹ Liebenberg argues that the reasonableness test is flexible and context specific and allows for on-going possibility of challenging socio-economic deprivations in the light of changing contexts. S Liebenberg (2006) *Stellenbosh Law Review* 5 at 29-31. See further S Liebenberg (2004) *ESR Review* 7 at 9. In criticising the reasonableness approach Bilchitz also criticises the approach because it fails to interpret and give content to the right in section 27(1). He notes that 'an approach that rejects the need to determine the content of rights is empty'. Bilchitz above note 70 at 56A:20-23. For more academic opinion on the reasonableness approach see also Davis above note 61 and Liebenberg above note 57 at 33-40-41.

⁷² Ngwena and Cook notes that 'even though the approach in TAC (to use the min core as part of the reasonableness test) has the advantage of flexibility and allows determinations to be made on a case-by-case basis, it may have the effect of inadvertently failing sufficiently to impress upon the state the compelling nature of socio-economic rights obligations'. Ngwena and Cook above note 17 at 143.

⁷³ Liebenberg (2006) above note 70 at 29. This argument is supported by Chirwa who argues that the Court has reduced, economic, social and cultural rights to group claims as far as enforcement of positive obligations is concerned. Chirwa above note 57 at 188.

⁷⁴ Davis above note 4 at 317-318.

means that ‘accessibility should be progressively facilitated, meaning that ‘legal, administrative, operational and financial hurdles should be examined and where possible, lowered over time.’⁷⁵ It also means that the state should not take any retrogressive steps.⁷⁶ The Court in *Grootboom* quoted with approval the International Covenant on Economic Social and Cultural Right (ICESCR) Committee’s interpretation of the concept of progressive realisation which *inter alia* requires states to move as expeditiously and effectively as possible towards the goal of full realisation of the rights and it requires states to justify any retrogressive steps.⁷⁷ Although the state is not burdened with strict time frames in which to fully realise socio-economic rights the Constitution requires all constitutional obligations to be performed diligently and without delay.⁷⁸ So the state should not stagnate and must make progress in advancing access to the relevant rights⁷⁹ by using existing and available resources effectively.⁸⁰

Bilchitz argues that the Constitutional Court’s analysis of progressive realization is problematic and deficient because it fails to guide the state in the fulfilment of their

⁷⁵ *Grootboom* above note 7 para 45 at 70A.

⁷⁶ Liebenberg and Pillay above note 16 at 30.

⁷⁷ Above note 7 at 70D. See also Committee on Economic Social and Cultural Rights ‘The nature of States parties obligationa (Art. 2, par 1): 14/12/90. CESCR General Comment 3. at para 9.

⁷⁸ Section 237 of the Constitution.

⁷⁹ S Liebenberg 2001 ‘Violation of Socio-Economic rights: The role of the South African Human Rights Commission’ in P Andrews and S Ellmann (eds) *The Post-Apartheid Constitutions: Perspectives on South Africa’s Basic Law*, 405 at 421.

⁸⁰ Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights (1986) at para 27: Available at <http://shr.aaas.org/thesaurus/instrument.php?insid=94> [Accessed 9 November 2007]. Note that General Comment 3 of the ICESCR Committee draws from the Limburg principles in setting out the nature and scope of State Parties obligations under the ICESCR. Thus the term progressive realization requires the State to do something to further access to health care during periods of economic growth and if the State fails to do anything (for example during times of economic growth) then it can be criticised as not progressively realizing the right. See Reidar K Lei ‘Health, Human Rights and the mobilisation of resources for health’ *BMC International Health and Human Rights* 2004 (4) <http://www.biomedcentral.com/content/pdf/1472-698X-4-4.pdf> [accessed 9 November 2007].

obligation to progressively realise socio-economic rights.⁸¹ It is submitted that the reason for the Courts reluctance to set down guidelines is the fact that the progressive realisation of a right depends on the available resources of the state and can thus only be determined over a period of time. It has also been noted that that setting time frames for when a state should have progressively realised a right would be problematic because the Court would have to review (for example) the state's five year plan on health care service delivery.⁸² Consequently the Court would then also have to review spending on the national budget to see if it is being used appropriately in order to give effect to the state's plan and in doing so the Court might have to substitute the views of the executive with its own views on how the budget should be better spent in order to give effect to the plan. These are not tasks which are suitable for courts to undertake.⁸³

2.4.4 Available resources

Section 27(2) requires the state to take measures within available resources to progressively realise the right to access health care services. The requirement that the rights must be realised depending on available resources can limit the ability to obtain constitutional guarantees.⁸⁴ Two outcomes of this qualification of 'available resources' are outlined to show the effect it has on the progressive realisation of rights.

⁸¹ See Bilchitz above note 70 at 56A-8.

⁸² Carstens and Pearmain above note 10 at 63.

⁸³ Above note 82. In *TAC* the Court held that 'The Constitution contemplates rather a restrained and focused role for the courts, namely, to require the state to take measures to meet its constitutional obligations and to subject the reasonableness of these measures to evaluation. Such determinations of reasonableness may in fact have budgetary implications, but are not in themselves directed at rearranging budgets'. See *TAC* above note 8 para 38 at 1047F.

⁸⁴ Bilchitz above note 57 at p20.

One, the requirement of realising rights progressively within available resources ‘places both a duty on the state and allows the state to raise a defence to a claim alleging that its progress in realising the rights is unreasonable’.⁸⁵ The Court held in *Grootboom* that the obligation to take measures to fulfil the right does not require the state to do more than its available resources permit.⁸⁶ The state can however not postpone its obligation to give full effect to the right indefinitely⁸⁷ and must use the resources that it has to its disposal effectively and sufficiently.⁸⁸ The state must also provide evidence of measures taken within its available resources to progressively realise the right in question.⁸⁹

Two, the court found in *Soobramoney* that the ‘rights themselves are limited by reasons of lack of resources’.⁹⁰ Bilchitz submits that this suggests that the availability of resources must also be considered in defining the very content of the right itself.⁹¹ In

⁸⁵ S Liebenberg above note 57 at 33:44. See also Liebenberg and Pillay above note 16 at 30. The authors goes on to note that the state must make sure that it correctly prioritises its budgetary and other resources to enable it to fulfil its constitutional commitment.

⁸⁶ *Grootboom* above note 7 para 46 at 70G. It has been said that when availability of resources are considered in relation to health care services regard must not only be given to the immediate cost of the treatment but also the duration of the treatment and the long terms savings, if the treatment is successful should be taken into account. See Van Bueren: above note 24 at 22-16.

⁸⁷ Liebenberg and Pillay above note 85. See also Ngwena above note 1 at 21-22. Section 237 of the Constitution is again relevant here.

⁸⁸ Liebenberg and Pillay above note 16 at 31.

⁸⁹ Ngwena above note 1 at 21. See also Bilchitz above note 57 at 21-23. Bilchitz also sums up the Constitutional Court’s criteria to the notion of ‘available resources’ as follows:

firstly, the Court will focus its enquiry upon the current allocations within a particular department that is directed towards the realization of a particular right; secondly, the Court will be more ready to order reallocations within existing budgets rather than require an increased budget in a particular area; and finally, the Court will not readily accept a defence that there is a lack of available resources where the exclusion of individuals or groups from a government programme constitutes unlawful discrimination or a serious invasion of dignity.⁸⁹ See Bilchitz above note 70 at 56A-8. For a summary of the Constitutional Court’s stance on reviewing government policy and budgets for socio-economic rights and the reasons for their cautious approach see Khoza above note 4 at 146. See also Ngwena above note 19 at 33 for a critique of the Constitutional Court approach in *Soobramoney* in respect of the available resources limitation.

⁹⁰ *Soobramoney* above note 5 para 11 at 1701E. This interpretation by the Court that the right not to be refused emergency medical treatment would also depend the availability of resources has been criticised by Pieterse where he notes *inter alia* that such an interpretation of section 27(3) did not accord with the textual setting of the provision. See Pieterse above note 32 at 83-85.

⁹¹ Bilchitz above note 57 at 19.

other words, the availability of resources is considered an element of the right without which the right itself cannot be recognised. Where the recognition of the right depends on the availability of resources it could mean that the state will be slow to give effect to it.

In terms of the CRC which is binding on South Africa, State Parties must use the 'maximum' of their resources to fulfil the right to health.⁹² The wording of the CRC appears to be more forceful than section 27(2). However Ngwena finds the formulation of section 27 to be realistic because it is sensitive to the 'quality and quantity of resources that a state can realistically marshal'.⁹³ Carstens and Pearmain also support this view and regard the requirement of available resources as the 'saving grace' of the right of access to health care services because it is flexible and makes the right practically implementable.⁹⁴ Bilchitz seems to express the same views but focuses his argument on the recognition of the right even when current resource availability does not make it possible to fulfil the right.⁹⁵ He submits that '[t]he recognition that people have rights even where there is no ability to realise them is important in that it recognised that in a world of scarcity, there are often cases where people are not able to acquire what they are entitled to. It suggests that as the scarcity is lessened, there are entitlements that are already in existence which must now be realised.'⁹⁶ This is exactly the point that Carstend and Pearmain make, that the requirement of available resources has the ability to adapt to circumstances.

⁹² Convention on the Rights of the Child article 4 read with article 24. In terms of international law 'available resources' includes resources the State has mobilised from the private or the international sector. See Chapman and Russel above note 53 at 10. See also Committee on Economic Social and Cultural Rights above note 77 at para 13.

⁹³ Ngwena above note 19 at 31.

⁹⁴ Carstens and Pearmain above note 10 at 77.

⁹⁵ Bilchitz above note 57 at 21.

Although it is clear that the concepts of available resources and progressive realisation do apply to children's rights it is unclear to what extent they apply to the children's clause given that section 28 does not refer to them. The Constitutional Court judgements do not clarify this. In a recent Pretoria High Court judgement⁹⁷ the court noted that section 28 does not contain internal limitations 'subjecting children's socio-economic rights to the availability of resources and legislative measures for their progressive realisation'. It found that although children's rights are generally subject to 'proportional and reasonable limitations' (in terms of the limitation clause) 'the absence of any internal limitation entrenches the rights as unqualified and immediate'. Furthermore the court said that 'budgetary implications ought not to compromise the enforcement of the rights and in this case urgent needs of the children outweighed the minimal costs or budgetary allocation problems'.⁹⁸ It is submitted that this court was able to come to this conclusion because its focus was on the children's clause only and it applied the clause to the circumstances of children only. This was not the case in *Grootboom* where the Constitutional Court was considering the link between section 26 and section 28 and how children's right to shelter tied in with their parent's right to housing. If the parties before the Constitutional Court in *Grootboom* were children only and the right to basic shelter was the only right in issue the court could have come to a different conclusion in its interpretation of section 28.

⁹⁶ Above note 95.

⁹⁷ *Centre for Child Law and Others v MEC for Education and Others* Case no 19559/06 30 June 2006 unreported.

⁹⁸ Above note 97 at page 7 of the judgement. This reasoning is in line with the Constitutional Court's conclusion in *Khosa* that given the impact the exclusion of non South African permanent residents to access social assistance had on their life and dignity, the denial of access far outweighed the financial considerations relied on by the State. See *Khosa* above note 9 para 82 at 539-540I-A.

In the meantime the findings of the Constitutional Court thus far makes it clear that qualifications of progressive realisation and available resources do apply to children's rights because they overlap with the socio-economic rights set out for everyone in the Constitution. Taking this into account and the reality that all socio economic rights in general do have financial implications for the state and that they are of such a nature that giving full effect to them takes time,⁹⁹ it remains to be seen whether the Constitutional Court will follow the approach of the Pretoria High Court should a similar case arise, but given its reluctance to interpret children's rights as separate rights from those given to everyone else, it is very unlikely.

To this end, the Court's interpretation of children's rights can be criticised for not according children's rights the priority they deserve.¹⁰⁰ Horsten *et al* argue that while no right is absolute, the fact that the wording of section 28 contains no internal limitation should convey a sense of priority in respect of children.¹⁰¹ By applying the reasonableness approach to children's rights it mean that children's rights are the same as everyone else rights,¹⁰² which leaves one to wonder why the constitutional drafters chose to separate children's rights at all. This interpretation of socio-economic rights is not unique in its application to the children's clause but rather falls generally in line with the Court's reluctance to interpret socio-economic rights as guaranteeing direct claims for

⁹⁹ Note de Vos' article where he clearly demonstrates that financial implications are not exclusive to socio-economic rights but that civil and political rights also places financial burden on the state. P de Vos (1995) SAPR/PL 233 at 235. The author further goes on to demonstrate the falsity of this distinction between socio-economic rights and civil and political rights at 239-244.

¹⁰⁰ Chirwa above note 57 at 190. See also Horsten and Jansen van Rensburg above note 57 at 127.

¹⁰¹ Horsten and Jansen van Rensburg above note 100. See also M Shung-King et al above note 34 at 138.

¹⁰² Chirwa above note 100.

material assistance from the State.¹⁰³ This reluctance does not accord with international law standards which apply to South Africa where claims for direct or indirect material assistance from the State are guaranteed as part of the States obligations to give effect to the rights.¹⁰⁴

2.4.5 GENERAL OBLIGATIONS

Although an exploration of children's health-rights entitlements need not go further than the text of the provisions hosting those rights, a discussion on the obligations attached to these rights is not complete without a consideration of the general obligations which apply to these rights and which are found in section 7 (2) of the Constitution. In line with international law, section 7(2) provides that the state has the duty to respect, protect, promote and fulfil the rights in the Bill of Rights.¹⁰⁵ This includes socio-economic rights.

There appears to be common understanding of the meaning applied to the state's duties to protect, respect, promote and fulfil the rights in the Bill of Rights.¹⁰⁶ The duty to respect

¹⁰³ Liebenberg above note 57 at 33-50-51.

¹⁰⁴ CRC art 18(2) and art 20(2) of the African Charter. See also . Rosa and Dutschke above note 53 at 233.

¹⁰⁵ These duties are also described as the primary, secondary and tertiary duty, primary duty (duty to respect); secondary duty (duty to protect) and tertiary duty (duty to fulfil). Sandra Fredman 2006 *Public Law* 498 at 500.

¹⁰⁶ See, South African Human Rights Commission 'The Right to Health Care, 5th Economic and Social Rights Report Series. 2002/2003 Financial Year. 21 June 2004 Introductory Section (ix) footnotes 5-8. In the 6th Economic and Social Rights Report 2006 the Commission builds on the previous interpretation of these obligations and summarise them in the Introduction of the report as follows:
The duty to respect implies an immediate obligation on the state to refrain from legislation or other actions that interfere with the enjoyment of these rights. The obligation to protect requires the state to take measures to prevent the right from being interfered with by state and non-state actors. The duty to promote and fulfil the rights in the Bill of Rights requires positive action on the part of the state to take legislative and other measures to assist individuals and other groups in obtaining access to their right. See also Khoza above note 4 at 35-37 and S Liebenberg and K Pillay above note 16 at 35-38. S Liebenberg above note 57 at 33-6. For practical examples of how these duties would apply to the right to health care services generally L London and L Baldwin-Ragaven (2006) 20 at 22. For examples on how these duties would apply in other circumstances see A Skelton and P Proudlock (2007) 'Interpretation, objects, application and

requires the state not to interfere with the enjoyment of the right. In respect of children's health service rights, it means that the state should not carry out, sponsor or tolerate any conduct which obstructs or hampers children's enjoyment of their health service rights.¹⁰⁷ The positive obligation to protect the right commands the state to prevent third parties from violating children's health service rights. The obligation to promote the right places a positive obligation on the state to 'create a conducive atmosphere in which people can exercise their rights through public education'.¹⁰⁸ When it comes to the duty to fulfil, the right the state is required to actively assist individuals in realising the right by putting measures in place to facilitate such realisation. For example, by making primary health care services free of charge to children under the age of 6,¹⁰⁹ the state is actively assisting indigent children of that age to realise their right to basic health care services.

These obligations have been explained as meaning two things in respect of the role of the State, namely,

'To create an enabling environment which makes it possible for people to gain access to the rights and improve their quality of life, and to remove barriers in the way of people gaining access to the rights, to adopt special measures to assist vulnerable and disadvantaged groups to gain access to the rights.'¹¹⁰

implementation of the Children's Act' in C Davel and A Skelton (eds) *Commentary on the Children's Act* 1-1 at 1-7-8.

¹⁰⁷ South African Human Rights Commission above note 106. Introductory Section (ix) footnotes 5-8.

¹⁰⁸ Above note 107.

¹⁰⁹ National Health Act 61 of 2003 section 4(3)(a).

¹¹⁰ Liebenberg and Pillay above note 16 at 27.

In order to give effect to children's health service rights the state is thus obliged to fulfil these positive and negative obligations.¹¹¹ Although the internal limitations qualify the states positive obligations it has been accepted by the Constitutional Court that such limitations do not apply to the states negative obligations not to interfere with current enjoyment of existing rights (duty to respect).¹¹²

2.5 CONCLUSION

The Constitutional Court in *Grootboom* considered the difference between children's right to shelter found in section 28 and everyone's right to housing set out in section 26, but no equivalent investigation has been done regarding the different health care provisions specifically for children and for everyone in general. Bilchitz notes correctly that 'the TAC judgement is notable for the virtual absence of any analysis of what the right to have access to health care services involves.'¹¹³ This chapter explored the scope and content of children's health service rights by focusing on the obligations and entitlements created by those rights. The significance about the entitlements and obligations attached to health care services is the power that comes with it. As far as children are concerned these rights give them the power to demand that health care services, in whatever form they are needed and available are accessible to them and also reveal to them the identity of those responsible for ensuring the effective exercise of this power. Although this chapter focused on the state's responsibilities in relation to health

¹¹¹ 'The distinction between negative and positive obligations may be outlined as follows: a negative obligation consists in having a duty not to interfere with the ability of someone to do something they are entitled to do; a positive obligation, on the other hand, requires one to act in a particular way to provide something for someone'. See Bilchitz above note 57 at 7

¹¹² *Jaftha v Schoeman and Others, Van Rooyen v Stoltz and Others* 2005 (2) SA140 (CC) see paras 31-33. *Grootboom* para 34 TAC, para 46 and *Jaftha* para 34

¹¹³ Bilchitz above note 57 at 6.

service rights they are not the only ones with obligations to children in respect of these rights. In fact the Constitutional Court has made it clear that parents are primarily responsible for giving effect to children's rights¹¹⁴ but the state is obliged to ensure that children's rights are protected when parental or family care is not available where for example the parents are too poor and are thus unable to provide the child with the care needed.¹¹⁵

Obligations and entitlements in respect of health service rights also gives children the power to hold those responsible for facilitating the enjoyment of their health service rights when they neglect those responsibilities. In this respect the Constitutional Court has played a significant role and has developed the jurisprudence on the adjudication of socio-economic rights. In many respects this jurisprudence seems to fail children in that the benefits created by these rights has been found to rest on qualifications not originating from the wording of the children's clause in section 28. However the jurisprudence on children's socio-economic rights especially their health service rights is by no means in its final stage of development¹¹⁶ and the powers emanating from the entitlements and obligations attached to children's health service rights should thus not be underestimated.

¹¹⁴ *Grootboom* above note 7 at para 77.

¹¹⁵ *TAC* above note 8 at para 79. Thus where the right to parental or family care could not be implemented the state has a direct duty to give effect to all the socio-economic needs of children as set out in section 28. See also J Sloth-Nielsen (2005): Children' in H Cheadle, D Davis and N Haysom (eds) ' South African Constitutional Law: The Bill of Rights (2nd ed) 23-1at 23-12. See Shung-King et al above note 34 at 135.

¹¹⁶ Infact the jurisprudence of socio-economic rights in general are still in an 'embryonic stage of development' See Devenish above note 4 at 106.

CHAPTER 3: CONSENT LAWS AND THE IMPACT OF CONSENT PROVISIONS IN THE CHILDREN'S ACT 38 OF 2005 ON CHILDREN'S ABILITY TO ACCESS HEALTH CARE SERVICE.

3.1 INTRODUCTION

By conducting an investigation into the entitlements and obligations inherent in health service rights the first chapter gave meaning to the concept of health rights as found in the Constitution. This was necessary to address the issue of vagueness in respect of health service rights in light of an opinion describing health rights in international law as vague. In addressing this issue of vagueness chapter 1 reviewed the jurisprudence of socio-economic rights and in doing so attempted to answer the question 'what does health service rights give children as holders of this right? This chapter explores the transition of health rights from the confines of the Constitution into national legislation and into practice. The chapter focuses on one element of health service rights, namely, accessibility to investigate this transition as driven by legislation.

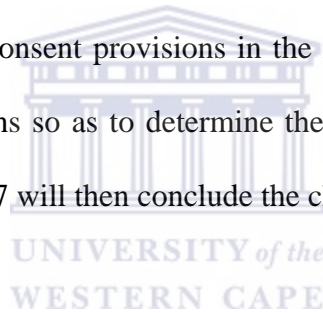
Accessibility in this chapter relates to the ability of a person to access health care services¹ and the primary focus here will be on a matter around accessibility, which affects children in a unique way, namely, consent. Described as 'arguably one of the most contentious areas of international children's rights,'² consent plays a big role particularly

¹ In the same way as Khoza explains 'access' to mean 'ability to get, have or use something' S Khoza (ed) (2007) *Socio-economic rights in South Africa: A resource book* 274. The focus in this chapter is on children's ability to get or use health care services.

² See G van Bueren (1998) 'Children's rights: balancing traditional values and cultural plurality' in G Douglass and L Sebba (eds) *Children's Rights and Traditional Values* 15 at 20. Carstens and Pearmain note as well that the question of consent have proven to be problematic when it comes to medical treatment

when it comes to children's ability to access health care services. In light of the enactment of the Children's Act 38 of 2005 and the commencement of certain provisions of this Act,³ children's consent to health care services can be considered afresh. The main aim of this chapter is to see how the consent provisions of the new Act and other legislation affect children's access to health care services.

To arrive at this conclusion, the chapter is set out as follows:⁴ Section 3.2 will look at the link between children's access to health care services and children's consent. Section 3.3 considers the meaning of consent and the common law requirement of consent. Section 3.4 looks at legislation, other than the Children's Act, hosting consent provisions. Section 3.5 will give a description of consent provisions in the new Children's Act and Section 3.6 will analyse these provisions so as to determine the impact they have on children's health service rights. Section 3.7 will then conclude the chapter.



3.2 THE LINK BETWEEN CONSENT AND CHILDREN'S HEALTH SERVICE RIGHTS

for minors. P Carstens and D Pearmain (2007) *Foundational Principles of South African Medical Law* 106-107.

³ Commencement of certain sections of the Children's Act 2005 (Act No. 38 of 2005). (Proclamation No. 13, 2007) GG 30030 3, July 29. All the provisions of this Act have not yet come into operation including some of the new sections on consent.

⁴ Please note that some of the information used here is taken directly as found in my chapter in the South African Health Review. See P Mahery (2006) 'Consent laws influencing children's access to health care services' in P Ijumba and A Padarath (eds) *South African Health Review* 167.

The Constitution⁵ protects children’s health service rights in sections 28(1)(c) and 27⁶. In chapter 2 it was found that the right ‘to access’ health care services meant that government should put measures in place to facilitate people’s access to health care services by ensuring that such services are available, affordable and effective. ‘Access’ also means placing health care services within geographical, economic, sociological and physical reach, of all people in South Africa without discrimination.⁷ The issue of access to health care services engages the question of rules regarding consent to health care services in a very unique way. Although the issue of consent does have something to do with health care services being ‘reachable’ as noted above, it does not relate to health

⁵ The Constitution of the Republic of South Africa Act 108 of 1996.

⁶ For convenience I restate the health service provisions relevant to this chapter:

Section 28

28. (1) Every child has the right –
- (a) ...
 - (b) ...
 - (c) to basic nutrition, shelter, *basic health care services* and social services. [my emphasis]

Section 27

27. (1) Everyone has the right to have access to –
- (a) health care services, including reproductive health care;

.....

(2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.

(3) No one may be refused emergency medical treatment.

⁷Carstens and Pearmain above note 2 at 41. In terms of international law the Committee on Economic, Social and Cultural Right has identified four dimensions of accessibility in respect of the right to health, namely, non discrimination, physical, environmental and financial accessibility. The dimensions of accessibility are outlined as follows:

Non-discrimination: This means that health; health facilities, goods and services must be accessible to everyone especially the more vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds.

Physical accessibility: This requires that health facilities, goods and services and the underlying determinants of health must be within safe physical reach for all sectors of the population especially vulnerable and marginalized groups including children and adolescents. It also requires adequate access to buildings for people with disabilities.

Economic accessibility (affordability): It requires health facilities, goods and services to be affordable to all. Payments for such services should be based on the principle of equity which demands that poorer households not to be disproportionately burdened with health expenses as compared to richer households.

Information accessibility: It includes the right to seek, receive and impart information and ideas concerning health issues, but it should not impair the right to have personal health data treated with confidentiality. See Committee on Economic, Social and Cultural Rights, General Comment 14 *The right to the highest attainable standard of health* at para 12 (b).

care services being geographically or economically reachable. 'Consent' in relation to the right to access health care services and in the context of this chapter, relates to the regulation of people's ability to obtain health care services through the power of consent. In other words the issue of consent has to do with health care services being actually or factually 'reachable' or 'unreachable' due to the operation of consent laws. The word 'reachable' should thus be interpreted to mean 'accessible' in the context of rules regarding consent.

Placing the argument in a practical framework might facilitate better understanding of the link between the issue of consent and children's health service rights, so consider the following. Consent laws determine that children of a certain age are able to access certain health care services on their own without the need for parental assistance or consent. This means that children who have not reached that age yet must be accompanied by their parents or guardians when they need health care services and only their parents or guardians can consent to the child receiving the relevant health care services (unless it's an emergency and parents or guardians cannot be reached to give the necessary consent, then other rules apply). This shows that, depending on their ability to consent, different rules apply when children need to access health care services. Different rules regarding consent implies different treatment of children based on their capacity to consent. This different treatment can in turn impact on their ability to fully enjoy the guarantees of service accessibility which stem from their health service rights.

3.3 THE MEANING OF CONSENT⁸

Consent has been explained as ‘the legal and ethical expression of the human right to respect for autonomy and self-determination.’⁹ In more simple terms, consent is a manifestation of a person’s will.¹⁰ In order for consent to be valid certain requirements have to be complied with. These requirements are (a) the consent needs to be given by a person capable in law to give consent, (b) consent must be informed, (c) the consent must be clear and unequivocal, (d) the consent must be comprehensive,¹¹ and (e) consent must also be given freely.¹² These are briefly considered below.¹³

3.3.1 Consent needs to be given by a person capable in law to give consent.¹⁴

A child is considered capable in law of consenting when he or she has the capacity¹⁵ and the competence to consent. For decades, children have however been regarded in law as incapable of giving consent in certain circumstance because of their age.¹⁶ Legislation around the world usually sets age as a determinate of children’s capacity to consent.

⁸ B Wood and P Tuohy have explored the different ways in which consent is understood in different disciplines and professions and the number of theories which has been developed in this regard. See B Wood and P Tuohy (2000) ‘Consent in child health: upholding the participation rights of children and young people’ in A Smith, M Gallop, K Marshall and K Nair (eds) *Advocating for Children: International Perspectives on children’s rights* 206 at 210-211.

⁹ S Jennings (2003) *Medical Law and Individual Autonomy: Competing Perspectives*. Galway Student Law Review Available at <http://www.nuigalway.ie/law/GSLR/2003/Medical%20Negligence.pdf> [Accessed 12 November 2007]

¹⁰ *Christian Lawyers Association v Minister of Health and Others (Reproductive Health Alliance as Amicus Curiae* 2005 (1) SA 509 (T) at p516.

¹¹ South African Law Commission (Project 122): *Assisted Decision-making: Adults with impaired Decision-making capacity* Discussion Paper 105 January 2004 45 at 57-58.

¹² C Burden-Osmond (2002) *Defence Counsel Journal*: Available at <http://www.albusiness.com/legal/contracts-agreements/1067823-1.html> Accessed 12 November 2007.

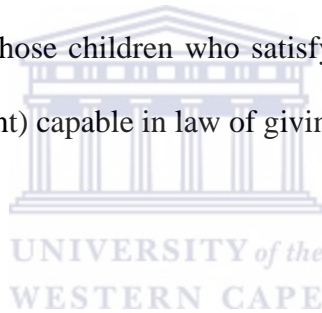
¹³ See *Castell v de Greef* 1994 (4) SA 408 (C) and R Thomas (2007) *SALJ* 188 for more discussion on these requirements.

¹⁴ W Joubert, J Faris (2004) L AWSA para 61 at 54. See also F Veriava (2004) *SAJHR* 309 at 312.

¹⁵ ‘Capacity to consent depends on whether the person consenting is able to understand the nature of the act for which consent is required.’ W Joubert and J Faris above note 14.

¹⁶ Factors such as youth, mental defect, intoxication or unconsciousness affect capacity to consent. See W Joubert and J Faris above note 14.

However this is not the only factor determining capacity to consent. In the case of *Christian Lawyers Association v Minister of Health and Others (Reproductive Health Alliance as Amicus Curiae)*¹⁷ (herein after referred to as the *Christian Lawyers* case) the court noted that ‘capacity to consent depends on the ability to form an intelligent will on the basis of an appreciation of the nature and consequences of the act consented to.’¹⁸ When it comes to competence, a child is considered competent to consent when he or she ‘achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed.’¹⁹ Although age is not the only factor determining a child’s ability in law to consent it is a factor which is able to negate the need to engage the other factors because of its inflexible nature. Despite this, legislatures around the world use ages of consent to make only those children who satisfy that age requirement (together with the competence requirement) capable in law of giving consent.



¹⁷ *Christian lawyers* above note 10.

¹⁸ Above note 10 at p515-516. The court went on to state that within the context of the Choice on Termination of Pregnancy Act 92 of 1996, ‘actual capacity to give informed consent, as determined in each and every case by the medical practitioner, based on the emotional and intellectual maturity of the individual concerned ... is the distinguishing line between those who may access the option to terminate their pregnancies unassisted on the one hand and those who require assistance on the other’ at p516.

¹⁹ *Gillick v West Norfolk & Wisbech Area Health Authority* [1985] 3 ALL ER 402 at 423. Ngwenya illustrates two approaches used to determine competence. The process approach considers the person’s ability to understand, to deliberate and express a preference about treatment without questioning the rationality or acceptability of the preference evinced. The outcome approach considers the rationality of the decision. According to him the process approach is preferred because it is in line with respect for self-determination. See C Ngwenya 1996 *Acta Juridica* 132 at 137-138. Freeman outlines seven levels of incompetence created by Beauchamp and Childress (2001)

1. The inability to evidence a preference or a choice;
2. The inability to understand one’s situation or relevantly similar situations;
3. The inability to understand disclosed information;
4. The inability to give a reason;
5. The inability to give a rational reason;
6. The inability to give reasons where risk and benefit have been weighed;
7. The inability to reach a reasonable decision, as judged, for example, by a reasonable person standard.

3.3.2 *Consent must be informed*

Informed consent generally requires the person giving consent to ‘understand the supplied information, comprehend the consequences of acting on that information, be able to assess the relative benefits and dangers of the proposed action, and be able to provide a meaningful response to the question of what should be done’.²⁰ It also requires the health care system to supply the patient with all the relevant information regarding a proposed procedure or treatment before the patient consents to the procedure or treatment being carried out.²¹ The notion of informed consent respects a patients’ personal integrity, because it affirms the patient’s right to determine what happens to his or her body.²²

In the *Christian Lawyers* case provisions of the Choice on Termination of Pregnancy Act 92 of 1996 were challenged as being unconstitutional and the issue of informed consent was considered. It was argued that the fact that the Act allowed girls under 18 to terminate their pregnancy without parental assistance or consent was unconstitutional because children under 18 did not have the ability to make decisions regarding a termination of pregnancies without assistance from their parents or guardians. In discussing the notion of informed consent the court found that the informed consent

Freeman however dismisses these by arguing that ‘if rights were to hinge on competence at any of the higher levels depicted [above] few [adults] would have them’. See M Freeman (2007) *International Journal of Children’s Rights* 5 at 12.

²⁰South African Law Commission above note 11 at 57-58. Thus to be considered ‘informed’ the consent must be based on substantial knowledge concerning the nature and effect of the act consented to. See W Joubert and J Faris (eds) (1999) LAWSA para 196 at 150.

²¹F Veriava above note 14.

²²B Wood and P Tuohy above note 8 at 207. A failure to obtain informed consent may be construed as negligence in certain cases. Joubert and Faris (1999) above note 20 para 196 at 147.

requirement rests on three independent legs, namely, *knowledge, appreciation and consent*.²³

‘The requirement of ‘knowledge’ means that the woman who consents to the termination of a pregnancy must have full knowledge of the nature and extent of the harms or risk’.

‘The requirement of ‘appreciation’ implies more than mere knowledge. The woman who gives consent to the termination of her pregnancy must also comprehend and understand the nature and extent of the harm or risk’.

‘The last requirement of ‘consent’ means that the woman must in fact subjectively consent to the harm or risk associated with the termination of her pregnancy and her consent must be comprehensive in that it must extend to the entire transaction inclusive of its consequences’.

The court found that what was central to the obtainment of termination of pregnancy services was the requirement of informed consent and that the Act did not allow any termination of pregnancy to take place where the woman was unable to give informed consent, despite her age.²⁴

3.3.3-3.3.4 Consent must be clear, unequivocal and comprehensive

Simply put this means that the doctor and patient must be absolutely clear about what exactly the patient has consented to. The patient must leave ‘no doubt that he or she is

²³ *Christian lawyers* above note 18.

²⁴ Above note 10 at p516.

prepared to undergo the suggested treatment notwithstanding the risk'.²⁵ In other words the patient must be fully aware of what he or she is consenting to.²⁶ That the consent must be 'comprehensive' implies that the informed consent process runs not only prior to, but also after the patient has received the treatment.²⁷ This means that the health professional should still inform the patient 'what is required once he has been discharged from hospital'.²⁸

3.3.5 Consent must be given freely

Consent must not be induced by force, threats or fraud.²⁹ In other words there must be an absence of any real or perceived coercive factors.³⁰

3.4 CONSENT LAWS (OTHER THAN THE CHILDREN'S ACT) HOSTING CONSENT PROVISIONS

Section 27(2) of the Constitution requires the state to take legislative and other measures to realise everyone's health service rights. As already established in chapter 1 of this thesis, this obligation attaches to children's section 28 rights as well. In response to these obligations, children health rights are given effect to in different pieces of legislation.

What follows now is an exploration of some of this legislation, but particularly those

²⁵ S Strauss (1991) *Doctor, patient and the law: A selection of practical issues* 12.

²⁶ W Joubert, and J Faris (2004) above note 14 at 54.

²⁷ R Thomas above note 13 at 191.

²⁸ Above note 27.

²⁹ W Joubert and J Faris (2004) above note 14 at 54. See also G J Nobel (2006) 'Consent, with Particular reference to HIV and AIDS' *CME (Continuing Medical Education): Your South African Journal of CPD* 79 at 79.

³⁰ C van Staden 'Can involuntarily admitted patients give informed consent to participation in research?' *South African Journal of Psychiatry* 10 at 12.

laws which contains provisions of consent with regards to children. For convenience I will refer to legislation which contain consent provisions as ‘consent laws’.

The following laws are aimed at giving effect to children’s health service rights

3.4.1 The National Health Act 61 of 2003 (the Health Act)

The Health Act is the main piece of legislation that sets out the general rules and regulations regarding health care procedures. Although the entire Act is not yet in force the provisions relating to consent are already operational.³¹ The rules of consent are provided for in section 7 of the National Health Act. This section requires a user to give informed consent before a health care service may be provided to the user. Section 1 provides that where ‘the person receiving treatment or using a health service is below the age of consent as established under the Child Care Act then ‘user’ includes the person’s parent or guardian or another person authorised by law to act on the first mentioned person’s behalf’.³² The National Health Act thus refers to the Child Care Act for the age threshold regarding children’s consent (see below for ages set out by the Child Care Act). To the extent that the Children’s Act will repeal the Child Care Act once the new Act becomes fully operational, the reference to the Child Care Act in the Health Act will accordingly be replaced by a reference to the Children’s Act.

3.4.2 The Child Care Act 74 of 1983

³¹ Proclamation of National Health Act, 2003. Government Gazette No. 27503 3, 18 April 2005.

³² In accordance with the requirement of informed consent the Health Act requires the user to have full knowledge of a range of issues relating to the treatment or health service such as his/her health status, the range of treatment options, benefits, risks and costs of the treatment. See Section 6.

Due to the fact that the provisions regarding consent to medical treatment and surgical operation in the new Children's Act are not yet operational the relevant provisions of the Child Care Act are still law. According to the Child Care Act a child can consent to his/her own medical treatment without the assistance of a parent or a guardian at the age of 14.³³ Furthermore at the age of 18 years a child (now considered a major in terms of the Children's Act)³⁴ can consent to his/her own operation without parental or guardian assistance.³⁵

3.4.3 The Choice on Termination of Pregnancy Act 92 of 1996

The issue of consent is addressed in section 5³⁶ of the Act. Informed consent must be given and only the pregnant woman needs to consent. A woman is defined as a female of any age.³⁷ This means that the ages of consent regarding medical treatment and surgery in terms of the Child Care Act as well as the Children's Act (once fully operational), do not apply to girls requiring a termination of pregnancy either through medical treatment or surgery. Although the health care worker must advise a minor to consult with her

³³ Section 39 (4) (b).

³⁴ Section 17 of the Children's Act. This section is operational.

³⁵ Section 39 (4) (a) of the Child Care Act. Although the Child Care Act does not explicitly mention the requirement of valid consent the common law rules regarding consent must be complied with and the child must understand what he/she is consenting to and consent must be informed, given, freely and equivocally. The Child Care Act also needs to be read with the National Health Act to provide comprehensive understanding regarding children and consent to health care.

³⁶ Only the relevant parts of the section is provided hereunder

Section 5: Consent

- (1) Subject to the provisions of subsections (4) and (5), the termination of a pregnancy may only take place with the informed consent of the pregnant woman.
- (2) Notwithstanding any other law or the common law, but subject to the provisions of subsections (4) and (5), no consent other than that of the pregnant woman shall be required for the termination of a pregnancy
- (3) In the case of a pregnant minor, a medical practitioner or a registered midwife or registered nurse, as the case may be, shall advise such minor to consult with her parents, guardian, family members or friends before the pregnancy is terminated: Provided that the termination of the pregnancy shall not be denied because such minor chooses not to consult them.

³⁷ Section 1.

parents or guardians, the termination of pregnancy cannot be denied if she chooses not to consult with them.³⁸ Thus, no parental or guardian assistance is required at any stage unless the girl agrees thereto. However, as the *Christian Lawyers* case indicated, informed consent rather than age is the key regulation to accessing termination of pregnancy under this Act.³⁹

3.4.4 Sterilisation Act 44 of 1998

Sterilisation can only be performed if a person who is capable of consenting consents thereto and that person is 18 years of age.⁴⁰ This implies that where a person is capable of consenting but below 18 then sterilisation cannot take place.⁴¹ A child under 18 can only be sterilised if failure to sterilise would result in his/her life being in jeopardy or his/her physical health being seriously impaired.⁴² In the case of a child under 18 year old the sterilisation can only take place if consent has been given by parents or guardians and when an independent medical practitioner has consulted with the child and has provided a written opinion to the effect that the sterilisation is in the best interest of that child.⁴³

3.4.5 Mental Health Care Act 17 of 2002

³⁸ Above note 36.

³⁹ Ellis and Faris (eds) (2006) LAWSA: Cumulative Supplement at 381.

⁴⁰ Section 2.

⁴¹ Carstens and Pearmain above note 2 at 100.

⁴² Above note 40. The Sterilisation Amendment Act 3 of 2005 has made some changes to the main Act one of which is the requirement of 'informed consent' and not merely 'consent' as prescribed in the main Act.

⁴³ Section 2(3)(i)(ii).

Where a mental health care user needing assisted care, treatment and rehabilitation⁴⁴ is below 18 years, an application for such care, treatment and services must be made by the parent or guardian of the user.⁴⁵ The Mental Health Care Act does not make it explicitly clear at what age a child can voluntarily consent to be a mental health care user. It states simply that voluntary care, treatment and rehabilitation means the provision of health interventions to ‘a person’ who gives consent to such intervention.⁴⁶ Furthermore it stipulates that a mental health care user, who submits voluntarily to a health establishment for care, treatment and rehabilitation services, is entitled to such care and services. In the absence of anything to the contrary it is submitted that in accordance with the provisions of the National Health Act and the Child Care Act (until its medical and surgical consent provisions are repealed) that a child needing mental health care in the form of medical treatment could at 14 years of age submit himself as a voluntary patient to access the treatment. If the mental health care involves surgery then an 18 year old could submit himself as a voluntary patient for the treatment.

3.5: LAW REFORM: THE CHILDREN’S ACT 38 OF 2005

The new Children’s Act was signed into law in June 2006 and came into operation partially in July 2007. Some of the provisions relating to children’s consent to health care services were among those that came into operation. The new Act has brought and will still bring significant changes to current consent legislation. The Child Care Act in

⁴⁴‘[A]ssisted care, treatment and rehabilitation’ means the provision of health interventions to people incapable of making informed decisions due to their mental health status and who do not refuse the health interventions. Where the health care intervention is provided to a person who is incapable of making informed decision due to his/her mental health status and that person refuses the health intervention but requires it for his/her protection or the protection of others then that person is an involuntary mental health care user. Section 1 of the Mental Health Care Act 17 of 2002.

⁴⁵ Section 27 (1) (a) (i) of the Mental Health Care Act 17 of 2002

particular will be repealed once the new Act commences fully. However some of the provisions of the new law have already replaced the operation of certain health services regulated through the Child Care Act. In this section the new provisions are set out and discussed in order to explore the impact that they have on children's right to access health care services. This section of the chapter is set out as follows: A brief history of the new law is provided followed by a description of the new provisions. This is then followed by a discussion of the new law for an assessment of the improvements and challenges this new law will bring for the fulfilment of children's health service rights.

3.5.1 Background to the Children's Act⁴⁷

Ten years ago the South African Law Commission (the Commission) was instructed to review the Child Care Act and to make recommendations for law reform to the Minister of Social Development.⁴⁸ Presented with this incredible task the Commission envisioned a law reform with the objective to produce a comprehensive children's statute based on: constitutional protection for the rights of children as commanded by the Constitution, the enforcement of these rights through the courts, the impact of HIV/AIDS on children; and South Africa's international obligations in terms of the Children's Convention and the African Charter.⁴⁹

⁴⁶ Section 1 of the Mental Health Care Act 17 of 2002

⁴⁷ For a more detailed and comprehensive account of the law reform process resulting in the Children's Act as it currently stands see A Skelton and P Proudlock (2007) 'Interpretation, objects, application and implementation of the Children's Act' in C Davel and A Skelton (eds) *Commentary on the Children's Act* 1-1 at 1-12-19.

⁴⁸ South African Law Commission 'Review of the Child Care Act' Discussion Paper 103 (Project 110) 2002 Executive Summary at 1.

⁴⁹ Above note 48.

After considering children's health rights, the Commission recommended that the age of consent for medical treatment without parental assistance should be lowered from 14 to 12 but that children below 18 should not be allowed to consent to surgery without their parents.⁵⁰ The Commission further recommended that there should be exceptions to the general rule in that a child of any age should be entitled to obtain information on and access to contraceptives and that any child should be able to obtain treatment for sexually transmitted diseases at any age.⁵¹

Following its review process the Commission drafted a Children's Bill which contained their recommendations and handed it to the Minister of Social Development in 2003. After considering the Bill in that same year it was tabled before Parliament. Due to the fact that the Bill contained provisions of current jurisdiction in terms of section 76 of the Constitution as well as provision in which national parliament had exclusive jurisdiction as set out in section 75 of the Constitution it was necessary to split the Bill into two parts. These two parts were then commonly referred to as section 75 Bill and the section 76 Bill. The section 75 Bill was considered first by Parliament. This Bill contained the provisions relating to the issue of children's consent to health care services. The Bill was

⁵⁰ Above note 48 Chapter 11 at 470.

⁵¹ The Commission's recommendations were based on four factors which it considered, namely (1) the *South African law and policy*: here the Commission considered the Constitution, legislation and relevant case law, (2) the *difficulties medical practitioners have in implementing consent provisions of the Child Care Act*: It was found that practitioners found it hard to obtain parental consent in non-emergency situations, (3) *comparative law*: The Commission found that many countries had exceptions to the general rules relating to consent (Such as exceptions allowing practitioners to treat a minor with a sexually transmitted disease without parental consent). The Commission found that in California children aged 12 could consent to medical treatment but that other conditions had to be met as well. (4) *An evaluation of the recommendations and comments received* in this regard also contributed to the recommendations made by the Commission. Above note 48 at 464-471.

passed and signed by the President in 2006 and is now called the Children's Act 38 of 2005. As said before, the Act came into operation partially on 1 July 2007.⁵²

3.5.2 Description of new consent provisions under Act 38 of 2005

The relevant provisions regarding consent are set out in Chapter 7, Part 3 of the Act with the heading 'Protective measures relating to the health of Children'.

3.5.2.1 Consent to medical treatment

This is covered in section 129 of the Act. This entire section is not in operation. In relation to medical treatment the relevant parts of section 129 (2) reads:

129 (2) A child may consent to his or her own medical treatment or to the medical treatment of 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

The Act will thus lower the age of consent to medical treatment from 14 to 12 years of age. However a safeguard is created to further protect children by explicitly requiring the child to be of sufficient maturity and have the mental capacity to understand the benefits, risks and social implications of the treatment. This is referred to as the maturity test in this chapter (and in chapter 4) and will be elaborated on later in the chapter when the issue of maturity is discussed separately.

⁵² See Proclamation above note 3. The section 76 Bill which is now known as the Children's Amendment Bill [B 19B—2006] has been passed by the National Council of Provinces in May this year and has also been passed by the National Assembly in November. Once this Amendment Bill is finalised and signed by the President it will together with the Children's Act of 2005 form the new children's law in South Africa.

3.5.2.2 *Consent to surgical operations*

With regards to surgery, section 129(3) reads as follows:

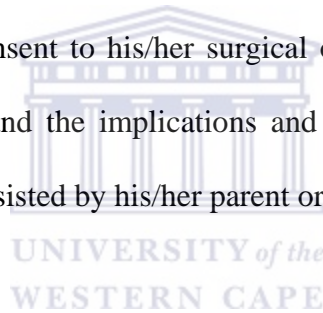
129(3) A child may consent to the performance of a surgical operation on him or her or

his or her child if—

- (a) the child is over the age of 12 years; and
- (b) the child is of sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications of the surgical operation; and
- (c) the child is duly assisted by his or her parent or guardian.

At age 12 a child can thus consent to his/her surgical operation and the child must be sufficiently mature to understand the implications and consequences of the operation.

The child also has to be duly assisted by his/her parent or guardian.



3.5.2.3 *HIV-testing, counselling and disclosing HIV-status*⁵³

There was no specific legislation that dealt with HIV testing before the new Act was promulgated. Much confusion existed as to whether HIV testing fell under the term ‘medical treatment’, and according to a legal opinion given to the Department of Social Development; HIV testing did in fact fall under ‘medical treatment.’⁵⁴ This is however no longer an issue since the provisions in the Children’s Act relating to HIV testing have come into operation and deals with HIV testing separate from medical treatment. The

⁵³ Sections 130-134 of the Act.

⁵⁴ L Gerntholtz . South Africa: Safeguarding Children’s Rights to Medical Care. Submission on the Children’s Bill. Portfolio Committee on Social Development. National Assembly, 27 July 2004. Human Rights Watch website. <http://hrw.org/english/docs/2004/07/27/safrie9150.htm> [accessed 9 October 2007].

sections stipulates that a child can only be tested for HIV where the test is in the best interest of the child and consent is provided, or where testing is necessary for the reasons set out in the Act.⁵⁵ The relevant parts of section 130(2) provides the following:

130 (2) Consent for a HIV-test on a child 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;

The ages of consent for an HIV test are reduced to 12 and lower if the child passes the maturity test. At face value it seems as if the Act does not require a 12-year-old to pass the maturity test. It is submitted however, that this 'omission' on the part of the legislature can be cured with the common law requirement of informed consent, which applies in all instances when any health care service is to be provided. The application of this requirement should thus prevent an immature 12-year-old from accessing an HIV test. These rules also apply in respect of children consenting to the disclosure of their HIV status.

3.5.2.4 Contraceptives

⁵⁵ Section 130 (1)

Subject to section 132, 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 test has been authorised by a court.

The provisions in the Children’s Act regarding contraceptives are in operation and reads as follows:

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.

As was the case with HIV testing, there was also no particular legislation that previously governed access to contraceptives for children. There was however a Policy Guideline on Contraception.⁵⁶ Furthermore, some contraceptives fell under medical treatment in terms of the Child Care Act and the age of consent for it was 14. This age threshold was also endorsed by the Policy.⁵⁷ Under the Children’s Act children can now access contraceptives at the age of 12 if the conditions are complied with.

3.6 ANALYSIS OF THE CHILDREN’S ACT

What needs to be considered now is the effect that these new consent provisions have on children’s health rights. Does it advance or hamper their ability to exercise their rights?

⁵⁶ National Department of Health ‘Policy framework for the provision and use of contraceptives’ in *National Contraception Policy Guidelines* Part 1 1-11 Part 2 18-38 2001 <http://www.doh.gov.za/docs/policy-f.html> Accessed 1 August 2007.

⁵⁷ Above note 56 Part 1 at 15.

What, if anything, are the complications and challenges it brings to children's health service rights. This is discussed by considering four aspects in the Children's Act regarding consent for children's health care services, namely, (1) the reduction of the age of consent, (2) the right to refuse consent when it comes to children's health care services, (3) the maturity test; and finally (4) general implications of specific provisions for children's health rights.

3.6.1 The age of consent

Consent is necessary and needed at all times when obtaining health care services. The right to privacy and physical integrity guaranteed to everyone demands respect for human autonomy and it is this respect for human autonomy that sets the requirement of consent as a precondition for enabling a health practitioner to supply a particular health care service to a patient.⁵⁸ When it comes to children legislatures around the world set particular ages for consent which would determine a child's ability to consent to medical treatment or surgery on their own without the need to have their parents' consent or assistance. This approach followed by legislatures is called the status approach.⁵⁹ As is clear from the legislation set out above, South Africa has been following this approach for a while and continues to do so again in the Children's Act.

⁵⁸ Consent to health care services such as medical treatment or surgery is also necessary to protect the health care provider from possible litigation as a result of a lack of prior consent from the patient.

⁵⁹ This is an approach in which age restrictions are used by legislatures to determine a child's competency to make informed decisions. It is one of three approaches used to determine capacity and competence of children's decision making ability. See P Alderson and J Montgomery (1996) *Health Care Choices: Making decisions with children* 72. The other two approaches have been describes as follows: (1) the approach based on an assessment of capacity to perform the function of taking the decision in question and (2) the approach which relies on considering the wisdom of the outcome of the child's decision.

The use of this approach could affect children's ability to access health care services. It might have negative or positive outcomes for children's fulfilment of their health service rights. In light of the continuous use of this approach particularly in health care legislation, it is submitted that a more focused impact analysis of this approach would benefit the health rights discussions being undertaken here. To this end a continuation of the investigation into the effects of the Children's Act on children's health service rights is undertaken in Chapter 3 where the impact of the status approach on children's health rights will be explored separately. Having said that, what must be dealt with here is the narrow point regarding the practical implications that reducing the age of consent would have on children's ability to access health care services.

3.6.1.1 Reduction of age of consent

In the Children's Act the legislature chose to lower the age of consent to medical treatment and surgery to 12 and even gives children below 12 the power to consent to HIV testing on their own. Setting the age threshold at 12 (and younger) is significant in itself,⁶⁰ and has sparked different reactions from the public⁶¹ and academic experts.⁶²

But what are the practical implications of this age reduction?

⁶⁰ Research indicates that the age group between 14-15 is set to be the 'approximate age that marks the transition from incompetence to universal competence regarding any treatment procedure, whether they are medical or surgical.' See Ngwena above note 19 note 20 at 138. See also R Weir and C Peters (2005) 'Affirming the decisions adolescents make about life and death' in M Freeman (ed) *Children, medicine and the law* at p560 which outlines a study done by The Committee on Child Psychiatry where it was found when assessing adolescent decision-making capacity that 'by 14 most children would be ready to participate meaningfully in the consent process in regard to research [and] there is little disagreement that above 14, all potential subjects must give their informed consent separate from their parents' However others have found that "the capacity to make an intelligent choice, involving the ability to consider different options and consequences, generally appear in a child somewhat between the ages of 11 and 14' See M Slabbert 'Parental access to minors' health records in the South African health care context: Concerns and Recommendations' (2005) vol 24 No4 *Medicine and Law* 743.

⁶¹ The following remarks appear from the Sowetan newspapers:

It has been noted in practice that ‘the issue of who can give consent for the treatment of children...can block children’s access to doctors offices and hospitals as much as lack of financial resources.’⁶³ Situations where parents first need to be traced before a health care service can be provided to a child below the age of consent, yet competent to consent would result in that child’s access to health care services being delayed or postponed until such consent is obtained. The situation is even more problematic when there are no parents able to give the necessary consent. By lowering the age of consent the legislature increases the amount of children who will be able to access medical treatment and contraceptives without parental or guardian’s assistance, if they are mature enough to consent. For this particular group of children in need of medical treatment or contraceptives the reduction of the age of consent could diminish the amount of delays experienced when parental consent is required but is not readily available or not wanted by the child. The reduction of the age of consent with regards to surgical operations would also be considered a welcome change for those who have criticised the Child Care

‘The section about HIV testing in the Act will cause both physical and emotional trauma for 12 year olds’ The consequences of HIV/AIDS results are too overwhelming for a 12 year old to handle’ See Z Mapumulo and R Mangope ‘Law allows kids private abortions’ *Sowetan*, July 5 2007 at 14.

‘12 year olds are too young and immature to make responsible decisions’

‘Only children older than 15 might be sufficiently mature to make decisions about their health’ See K Seekoei & M Buthelezi ‘Dads get rights’ *Sowetan* July 12 2007 at 3.

‘For the government to burden 12 year olds with momentous decisions such as medical treatment, surgical operations and HIV-testing without parental consent is not right.’ “At 12 the maturity level of a child is at its weakest point to cope with the result of their HIV status’ See Z Mapumulo ‘Act not good for children-Mandela Fund’ *Sowetan* July 6 2007 at 9.

⁶² A Skelton ‘Condoms for kids?’ *Mail and Guardian* July 13-19 2007 at 32.

⁶³ A Bittinger (2006) *Florida Bar Journal* 24. Retrieved 12 November 2007, from Westlaw online database.

Act for being overly restrictive by requiring the minor to be above 18 in respect of surgical treatment.⁶⁴

A practical advantage of the reduction of the age of consent for children requiring surgery could be found in situations where young children below the current age of consent require surgery. In practice, a case could arise where a patient below 18 needs surgery which the responsible health care provider has advised him or her together with a parent to undergo, but the parent refuses to consent despite the child patient actually wanting to undergo the surgery. In this case the health care provider finds himself in the middle of conflicting interests between his or her patient and the person legally responsible for consenting to the surgery. The health provider will not be able to perform the surgery without the consent of the parent despite the approval of his patient and would either have to follow the instructions of the parent or attempt to get ministerial or court ordered consent. By lowering the age of consent for surgery to 12, the health care provider would be able to take instructions from his young patient who is assisted by a parent and would be saved in certain situations from having to deal with conflicting interests arising from a disagreement between a parent and a young patient below 18 years of age (but not younger than 12).

On the other hand, the lowering of the age also has other implications for health care providers because they would now have to deal with an increased number of children capable of consenting to medical treatment without their parents. For example, in a case

⁶⁴ To this end the South African legislature was said to be exercising far more circumspection than is warranted because empirical findings did not support such a high age to be required for children accessing

where a child's age is questioned, health care workers have to follow certain procedure to determine the child's age. With the increase in the amount of children now able to consent, health care workers may have to deal with an increased amount of children whose ages have to be determined if their age is not clear. Whereas health care workers only had to determine the age of those children who might or might not have been 14 years of age for purposes of consent, they would now have to also determine the ages of those children who may or may not be 12 years of age for purposes of consent.

3.6.2 Refusal of treatment

Laws which give adolescents the right to consent often do not give them the right to refuse treatment.⁶⁵ McQuoid-Mason notes that the right to consent to treatment includes the right to refuse treatment.⁶⁶ It is submitted that health services rights read with the right to physical integrity protected under the Constitution entitles the right holder to obtain as well as to refuse health care services.⁶⁷ Unlike the Child Care Act, the Children's Act has specific provisions regarding the refusal of consent. Such refusal can also affect the ability of children to obtain health care services. This is explored below by looking at parents refusing treatment needed by their children and children refusing treatment for themselves.

surgery'. See C Ngwenya above note 20 at 143 and 147.

⁶⁵ L Ross (2006) 'Health care decision-making by children: Is it in their best interest?' In M Freeman (ed) *Children, medicine and the law* 487 at 490.

⁶⁶ D McQuoid-Mason (2006) SAMJ 530 at 531.

⁶⁷ See Veriava above note 14 at 313.

The rules regarding refusal to consent to medical treatment and surgical operations are set out in section 129 of the Children's Act and they read as follows:

- 129 (7) The Minister 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.
- (8) The Minister may consent to the medical treatment of or surgical operation on a child if the child unreasonably refuses to give consent.
- (9) 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
- (10) No parent, guardian or care-giver of a child may refuse to assist a child in terms of subsection (3) or withhold consent in terms of subsections (4) and (5) by reason only of religious or other beliefs, unless that parent or guardian can show that there is a medically accepted alternative choice to the medical treatment or surgical operation concerned.

3.6.2.1 Parents refusing consent

When treatment for a child is withheld or delayed because a parent refuses to give consent a child's right of access to treatment is again affected. Parents who refuse to grant consent to their children's medical treatment or surgery usually do so for reasons that 'pertain more to their rights as parents rather than the rights and interests of the child.'⁶⁸ In most cases parents refuse to give the required consent for religious reasons.⁶⁹

Although there have not been cases in South Africa reported where adolescents sought

⁶⁸C Breen (2006) *Age Discrimination and Children's Rights: Ensuring Equality and Acknowledging Difference* 55.

⁶⁹ For an outline of comparative case law where parents refuse to consent to medical treatment for their children because of their religion see M Boyer (2004) *Whittier Journal of Child and Family Advocacy* 147. Retrieved, 12 November 2007, from Westlaw online database.

treatment despite parents refusal, there has been cases where younger children (mainly infants) needed treatment and parents refused, forcing the practitioner to apply for ministerial or court ordered consent. In this regard the case of *Hay v B*⁷⁰ is instructive and its facts are briefly set out below.

This is the most recently reported case in South Africa in which an infant needed urgent blood transfusion but the parents refused to consent to such treatment because of their religion. Jajbhay J held that it was in the baby's best interest that his right to life is protected and that the religious beliefs of his parents could not override this right.⁷¹ The result of the court's findings is that where a situation occurs where parents refuse to consent to life saving treatment for their minor children based on religious beliefs then such a refusal can be considered unconstitutional and would therefore be unlawful.⁷²

In this decision the focus was more on the child's right to life and the best interest of the child principle⁷³ than the child's right to access health care services. However the case clearly indicates the effect that a parents' refusal has on the child's ability to access treatment without delay.

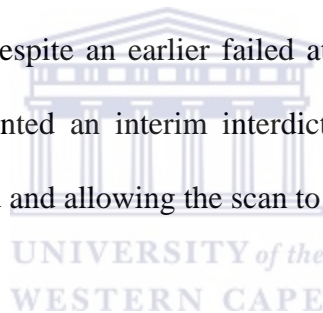
⁷⁰ *Hay v B and Others* 2003 (3) SA 492 (W)

⁷¹ Above note 70 at p495.

⁷² See D McQuoid-Mason (2006) *SAMJ* 29 at 29.

⁷³ The best interest principle operates in directing the court 'to exercise the discretion it possesses in its capacity as upper guardian of minors to promote the interest of the child rather than focusing on the rights and entitlements of parents'. See I Currie and J de Waal (2005) *The Bill of Rights handbook* 617-618. The Court must make sure that 'the best interest principle is not used by adults to override the wishes and interests of the child. See Wood and Tuohy above note 8 at 208. The authors suggest that 'a balance can be achieved by ensuring that children are well informed to their level of understanding and that their views are taken seriously'.

Many of the cases involving parents refusing to consent to treatment for their children are not reported in the law books but are highlighted in newspapers. Two such cases were reported in the Pretoria Newspaper. The first case involved a father who refused to consent to a brain operation for his child. The Centre for Child Law at the University of Pretoria intervened and was about to launch an urgent application to the Pretoria High Court to obtain court ordered consent when the Minister of Social Development gave the necessary consent overruling the father's refusal.⁷⁴ In another incident reported in the newspaper earlier this year the mother of a sixteen year old refused permission for a Limpopo hospital to conduct a scan on her daughter who was possibly suffering from a life threatening cancer. The mother's refusal was based on her belief that traditional healers could treat the child (despite an earlier failed attempt by a traditional healer to treat the child). The court granted an interim interdict to the hospital to prevent the mother from removing the child and allowing the scan to be conducted.⁷⁵



The provisions of the Children's Act set out in section 129(10) above respond to these situations and will thus not allow parents to refuse to consent to their children's medical treatment or operation based on their religions unless those parents could show that the alternative treatment of their choice is medically acceptable. The onus is a stringent one seeing that it would be easier for people in the medical profession to show that the alternative chosen by the parent is not medically acceptable then it would be for parents to show that it is medically acceptable. However, the objectives of these provisions and the *Hay* judgment are to prevent parents from frustrating children's access to health care

⁷⁴ Z Venter 'Girl to go under the knife on Monday' Pretoria News; Wednesday 1 November 2006.

⁷⁵ Z Venter "Tug-of-war over teen stricken by cancer" Pretoria News (Ed 1) 26 January 2007 at p 3.

services because of their religious convictions or their lack of faith in modern medical procedures. This objective serves the rights of the child and should not be overshadowed by issues regarding onus.

3.6.2.2: Refusal of consent by a minor

Does a minor who has the capacity to consent also have the right to refuse to consent?

In almost all instances the child's competence to consent becomes questionable only when there is disagreement between the child, the parent and/or the practitioner.⁷⁶ Not only is the child's competence to refuse at issue but the child's right to refuse treatment is questioned.

In terms of current law in the forms of the National Health Act, health care users are expressly given a right to refuse consent.⁷⁷ 'User' in terms of section 1 of the Health Act refers to a child above the age of consent as set out in the Child Care Act. As said before, once the Children's Act replaces the Child Care Act this reference to 'user' will apply to children competent to consent under the Children's Act. But does the Children's Act also make provision for children refusing treatment?

The Children's Act does not explicitly give children with the capacity to consent the right to also refuse treatment. This right could however be implied from section 129(8) read

⁷⁶P Alderson (2005) 'In the genes or in the stars? children's competence to consent' in M Freeman *Children, medicine and the law* 550. See also I Kennedy (1988) *Treat me right: :essays in medical law and ethics* 55.

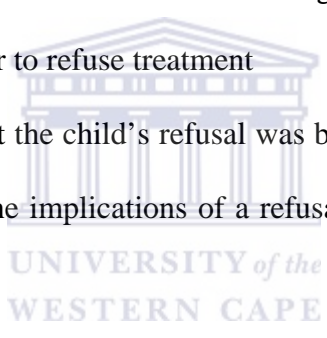
⁷⁷ Section 6(1)(d) reads:

Every health care provider must inform a user of-

(d) the user's right to refuse health services and explain the implications, risks, obligations of such refusal.

with section 129(2) of the Act. Section 129(8) authorises the Minister of Social Development to give consent to medical treatment or surgery for the child if the child unreasonably refuses. This implies that the child may refuse the health care service but cannot do so unreasonably.

The section does not give any indication of what could be considered unreasonable and how the Minister would go about enquiring on the reasonableness or otherwise of the child's refusal. What would the Minister take into account when considering whether the child's decision is reasonable or not? It is submitted that the reasonableness of the decisions should take into account *inter alia* the following:

- 
- (a) the maturity of the minor to refuse treatment
 - (b) informed refusal (i.e that the child's refusal was based on information supplied to him informing him of the implications of a refusal and the child still refused the treatment)
 - (c) The benefits, risks and other consequences of the refusal for the minor and his family, and
 - (d) The best interests of the minor.

The maturity test should ensure that the minor is capable of consenting in the first place. In light of the elements of informed consent as set out in the *Christian Lawyers case*⁷⁸, the elements must also be applied to situations where consent is refused. Thus, all the information should be given to the minor, including information on the benefits, risks and other consequences of the refusal. The best interest principle should then be used to

ensure that the minor's best interest is given paramount consideration in cases where he or she refuses treatment.

Section 129(9) authorises the High Court to consent to treatment or surgery of the child in any instance where the person who is allowed to give consent in terms of section 129 refuses to give it. Those capable of consenting include children who are 12 years and older and are mature enough to consent to give consent. This means that those children would also be able to refuse treatment.

Refusal by minor who lacks capacity to consent

In her article Margaret Brazier notes that '[a] ... difficult issue surfaces where an intelligent child suffering from no degree of mental disorder refuses treatment. If he makes a decision which the law would be obliged to accept were he 18 [or 12 in terms of the Children's Act], is coercion on the ground of minority justifiable?'⁷⁹ Coercion here is a result of a third party having the power to override the decision of the child even when the child has the competence but not the capacity to refuse the treatment. This is a dilemma faced by many practitioners⁸⁰ and research has shown that in other jurisdictions there is no set way of dealing with such minors refusing consent. In Canadian cases for example the consensus is that children can consent or refuse medical treatment if they are mature and understand the nature of the treatment and the consequences of not receiving

⁷⁸ See above note 23.

⁷⁹ See M Brazier and C Bridge (2005) 'Coercion or caring: analysing adolescent autonomy' in M Freeman (ed) *Children, medicine and the law* 84 at 103.

⁸⁰ It has been said that although legally the practitioner is obliged to do what the parent wants when the child is incapable of consenting but "[e]thically, the physician should be guided by considerations of patient autonomy and the power of moral persuasion to follow the instructions of the adolescent, unless a

that treatment.⁸¹ However English cases seem to take a different approach. When it comes to minors refusing treatment the English court seems to take a more strict approach and not limited to the mature minor test created in the groundbreaking case of *Gillick*.⁸² Recent cases indicate the willingness of English courts to override the decisions of a minor even if he or she was competent. In some cases the court would more readily decide that the child was not competent to make it easier to override the child's decision.⁸³

particular adolescent demonstrates that he or she lacks sufficient decisionmaking capacity..." See Weir and Peters above note 60 at 566.

⁸¹ C Burden-Osmond (2002) *Defence Counsel Journal*. Available at <http://www.allbusiness.com/legal/contracts-agreements/1067823-1.html> [Accessed 12 November 2007]

⁸² In *Gillick* above note 19, the court created the mature minor doctrine which required a minor only to be sufficiently mature and have the intelligence to understand the treatment being proposed before such treatment could be given. Thus age was not considered the determining criteria to consider when a child wanted to access health care services without parental or guardian consent. Later cases dubbed the court criteria as the *Gillick test*, and a child had to be *Gillick competent* before the child could get treatment without parental or guardian assistance. There has however been a move away from the *Gillick* approach as far as children refusing consent are concerned.

⁸³ Examples of English Court cases in which the minor's refusal of medical treatment was at issue:

Re R a 15 [1991] 4 All ER] 177 year old refused consent to the administration of medication. She was found not to be *Gillick* competent. The court found that where the child was a ward, and as a wardship court it had the power to override a *Gillick*-competent child. In Re (A Minor) (Wardship: Medical Treatment) 1993 1 FLR 386 a fifteen year old suffering from leukaemia in need of blood transfusion refused treatment because of his religion. His parents also refused the treatment. The hospital applied to the court for an order overriding their refusal and to provide the treatment. The court considered the boy a ward of the state and approved the hospital's application holding that the boy '[did] not have a full understanding of the whole implication of what the refusal of that treatment involves' at 386. Another minor aged 10 who refused to consent was overridden by a court order in Re S (A Minor) (Medical Treatment) 1994] 2 FLR 1065. This was done for the following reasons '[f]irstly, the influence of the religion and in particular the mother's influence and secondly the nature of the child's chronic illness, her reaction to it and her understandable reluctance to continue the arduous course of treatment'. In Re S [1994] 2 FLR 1065 a 15-year old Jehovah's Witness was forced to undergo a blood transfusion because she was not considered *Gillick* competent. Re L [1998] 2 FLR 810 concerned a 14 year old Jehovah's Witness who was also forced to undergo blood transfusion because the court held that she lacked the constructive formulation of an opinion which occurs with adult experience, at 812. Re W [1992] 4 All ER 627 involved a competent 16-year-old who suffered from anorexia who was refusing treatment for her disorder. Taking into account what is in the best interest of the child, the rights of the parents, and the doctor's position the court found 'No minor of whatever age has power by confusing consent to treatment to override a consent to treatment by someone who has parental responsibility for the minor' at 639. It was found further that the doctor only needs the consent of one person and he can proceed, see 635. Re M [1999] 2 FLR 1097. Here a 15 year old who was not found not to be *Gillick* incompetent was still forced to undergo a heart transplant (contrary to her wishes) because the court found that it was obliged to prevent underage minors from making dangerous mistakes. Re P [2004] 2 FLR 1117 involved a nearly 17 year old Jehovah's Witness who suffered from a condition which created a tendency of bleeding. In light of this it was likely that at some stage he would be in need of blood or blood products. His competence to refuse treatment was not in question but the court

The fact that capacity to consent depends not only on the child's maturity but mainly on the child's age as well creates difficulties for children who are mature enough to consent or refuse treatment but have not reached the age of consent yet. As indicated above, the right to consent also includes the right to refuse treatment, so if the child is mature enough to consent he should also be mature enough to refuse treatment and in such cases the age of the child should not prevent the child from being able to refuse treatment. It has been suggested that 'consent to and the refusal of medical treatment are not necessarily equivalent and that ethically speaking, a higher level of competence is required to refuse than consent to such treatment'.⁸⁴ Even if this is true, it is submitted that the problem is not with the need to test the maturity of the child but rather that the child's age could prevent him or her from refusing (or accepting without parental assistance) medical treatment despite the child passing the maturity test. This point again engages the issue of the use of the status approach in determining the child's capacity to consent which is discussed more in chapter 4. The discussion on aspects of the Children's Act impacting on children's health service rights continues below.

3.6.3 *The Maturity test*⁸⁵

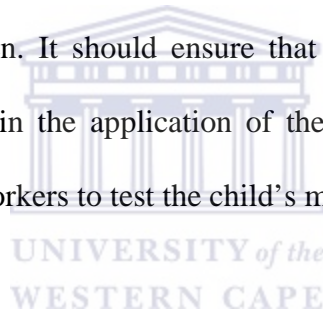
found that it had a duty to ensure that children survive to attain majority. For a more detailed discussion of these cases see: M Freeman (2005) *International Journal of Children's Rights* 201 at 205-209.

⁸⁴ See J Will (2005-2006) *Journal of Contemporary Health Law & Policy* 233 at 289 & 295. Retrieved 12 November 2007, from WESTLAW online database.

⁸⁵ The mature minor doctrine is based on rules which 'allows a minor who is sufficiently intelligent and mature to understand the nature and consequences of a proposed treatment to consent to medical treatment without consulting his or her parents or obtaining their permission' See H Boonstra and E Nash (2000) *The Guttmacher Report on Public Policy* 4. Available at <http://www.guttmacher.org/pubs/tgr/03/4/gr030404.html> [Accessed 12 November 2007]

As said before, the provisions of the Child Care Act regarding consent to medical treatment and surgery are still in operation since the relevant sections of the Children's Act are yet to commence. The Child Care Act and the other Acts mentioned in section 2 do not explicitly require a child to be mature enough to make a health care decision. However, as stated before the maturity requirement falls within the rules of informed consent. The explicit inclusion of the maturity test in section 129 of the Children's Act is however significant and will affect children's health service rights.

By explicitly requiring the child to be mature enough to understand the consequences of consenting to the necessary health care service the Children's Act strengthens the protection of immature children. It should ensure that the child's maturity is actually tested which might not occur in the application of the Child Care Act which fails to explicitly require health care workers to test the child's maturity.



Other problems with the maturity test have been identified in Canada, where the mature minor doctrine is also used and these are instructive. One of the problems is the lack of a standardised test to determine maturity and the other one involves the identification of who is suppose to assess maturity.⁸⁶

A lack of a standardised test in the Act for determining maturity could create inconsistency in the treatment of children not only by practitioners but also courts. To this end it has been suggested that '[a] standardized test such as a mandatory psychological analysis or evaluation would provide a consistent method for courts to

determine a child's maturity level and understanding of the consequences of rejecting medical treatment.'⁸⁷ The problem relating to non-identification of precisely who is supposed to assess maturity is also created in the new provisions in the Children's Act. In many instances it is assumed (and may in fact be) that the practitioner is the one⁸⁸ who would assess maturity but in practice it may be different.⁸⁹ Where the practitioner is in fact the one who obtains the necessary consent, he or she is responsible for assessing maturity. The problem is that practitioners are not trained to assess the decision making ability of children and there is no test to evaluate maturity.⁹⁰

3.6.4 Other general implications of these consent provisions

3.6.4.1 Requirement of 'assistance' for surgical operations

Section 129 of the Children's Act requires the child to be duly assisted by a parent when the child consents to surgery. The Act does not make it clear what is meant by 'duly assist'. This is problematic because the absence of a definition creates confusion about whether this requirement of parental assistance refers to parental advice or supplementary

⁸⁶ Above note 12.

⁸⁷ Above note 12.

⁸⁸ To the extent that the assumption is true it is was found that the heavy responsibility that the test places on medical practitioners is acceptable because the responsibility is in the hands of a "learned and highly trained profession regulated by statute and governed by a strict ethical code which is vigorously enforced" See above note 97. The Law Reform Commission of New South Wales (NSW) 'Minors' consent to medical treatment' Issue Paper (2004) 24 at para 2.10

⁸⁹ The Children's Institute of the University of Cape Town held a consultative workshop on draft regulations to the Children's Act 38 of 2005 pertaining to consent to medical treatment, surgical operations and HIV testing on 11 June 2007. Some health practitioners were present and discussed regulations regarding the consent provisions in the Children's Act. At the workshop it became evident that in practice the person who obtains the necessary consent is not the practitioner in most cases. In some instances the clerk obtains the consent. Since the person who obtains the consent should be the one to assess the capacity to consent it would seem that practitioners are not the only ones who would under the new provision be responsible for assessing maturity.

⁹⁰ Ross above note 65 at 490.

support, or whether it entails parental approval.⁹¹ It is submitted that an interpretation given to ‘duly assist’ should not include a power to enable parents to prevent a competent child from accessing the required surgery. This is so because ‘assistance’ is a responsibility placed on the parent in respect of the child, but such responsibility should not determine the ability of the child to exercise the right to consent to the surgery.

3.6.4.2 Requesting contraceptives

Section 134 of the Children’s Act regulates the age at which a child can, without parental assistance, request and be provided with contraceptives. The section does not appear to engage the issue of consent (by the child) or the maturity of the child and focuses on the ability of the child to access contraceptives on request. This makes the section (particularly the provision dealing with contraceptives other than condoms) problematic. This is so because children might be forced by their abusers, boyfriends or peers to use contraceptives even if they don’t want to. If consent was a necessary requirement then in such cases there could be no valid consent because the consent is not given freely.

Section 134(2)(a) requires proper medical advice to be given to the child when she requests contraceptives like for example, the pill or the injection. However the child is not engaged in discussion by this section because it doesn’t require the child to understand the advice being given (no maturity test required). By not requiring proper consent from the child who requests contraceptives the provisions fail to command the health care provider to ensure that the child *actually* understands the information supplied.

⁹¹ Slabbert above note 60.

This does not mean however that all that is required for a 12 year old to access contraceptives is that she is 12 years or older, has been given proper medical advice and has passed a medical examination. Section 134(2) provides that contraceptives other than condoms may be provided to the child on request by the child if requirements (a) to (c) have been complied with. The section does not say that the contraceptives must be given to the child when those requirements have been met. This section could thus be interpreted to mean that even if the child is 12, has been advised on the use of a particular contraceptive and passed the medical examination that child can still be refused contraceptives because of factors such as, maturity, undue pressure to obtain contraceptive or other factors which the health care worker took into account.

3.6.4.3 Care-givers and guardians' consent

Access to health services for children is not only increased through the lowering of the age of consent but also through the added amount of people authorised to consent to the treatment of children. Currently (under the Child Care Act) caregivers⁹² are not permitted to consent for children's medical treatment and this necessitates the need for court ordered or ministerial consent, which would generally hold the consequences of delay

⁹² Defined in the Children's Act as meaning 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; and
- (g) the child at the head of a child-headed household;

and prevention of health services for children with no parent or guardian but who have only caregivers. With caregivers such as the head of a shelter or a child and youth care worker, being authorised under the Children's Act to consent to the treatment of children living outside their family environment like children living on the streets the delay effect that the current laws have on the exercise of such children's health care rights would thus be reduced.

On the other hand, the Children's Act does not allow a caregiver to consent to surgery on behalf of a child.⁹³ So for example a person heading a shelter will not be able to consent to a surgery for a child under 12 who has no parents, lives on the street and makes use of the shelter. Even section 32 of the Act which gives persons who have no parental rights and responsibilities but who cares for a child (such as a child's granny) the right to consent to the medical treatment of the child does not allow for consent to surgery by that person. A reason advanced for this 'omission' in the Act was that it would be easier for a medical person to ascertain whether someone was a parent, than it would be to ascertain whether that person was a caregiver or primary caregiver.⁹⁴

Also, when it comes to children incapable of consenting to an HIV test, section 130(2) does not mention guardians as people empowered to consent on behalf of such children.

⁹³ Section 129 (5)

The parent or guardian of a child may, subject to section 31, consent to a surgical operation on 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 operation.

⁹⁴ Parliamentary Monitoring Group Minutes 24 May 2005

<http://www.pmg.org.za/viewminute.php?id=5883> Accessed 3 August 2007

This is odd seeing that the other consent provisions clearly include guardians as having decision making powers. It could however be a mere technical error made in the drafting process but it does need to be rectified to enable guardians to consent to an HIV test on behalf of the children they have guardianship over. The inability of guardians to consent could again lead to delays of accessing this particular health care service for the children involved, because the health care worker would have to obtain consent from the provincial head of social development which could be time consuming.

3.6.5 Conclusion

It is true that although many children were born after the 1994 elections, they continue to face many challenges including a lack of access to services.⁹⁵ The Constitution guarantees children the right to basic health care services and a right of access to health care services including reproductive health care services. These rights read together create an entitlement of children to be able to access health care services. It is not only physical or economic access to services that must be protected but also access to services enabled by consent laws.

By reducing the age of consent, creating the maturity test and authorising previously unauthorised persons to consent to the treatment of particular children, children's chances of accessing health care services are effectively increased. However the new law is not without challenges. The lack of a standardised test for maturity could lead to a discrepancy in the way health practitioners assess maturity which could negatively affect

⁹⁵ Child Sexual Abuse and Exploitation in South Africa: A Report by the Community Agency of Social Enquiry (CASE) Commissioned by Save the Children Sweden. April 2005. Executive Summary.

children's ability to access health care services. The lowered age of consent increases the amount of children able to access health care on their own and places many more responsibilities on health care providers. Given the crises in the shortage of health care professionals available in the country⁹⁶, the health system might not be able to respond to these added responsibilities created by the Act. However, despite these and other challenges brought about by the consent provisions in the Children's Act, such challenges are to be expected since no new law comes without them. Compared to the Child Care Act and other health care legislation the Children's Act creates more obligations and safeguards for children needing health care services and could respond more effectively to the current health care needs of minors once fully and accurately implemented. The Act is thus an improvement on laws giving effect to children's health service rights.



⁹⁶ L Comins 'Come back home, teachers and nurses-there's work to do here' *Pretoria News*, July 23 2007, Front page.

CHAPTER 4: CONSTITUTIONAL ANALYSIS OF THE STATUS APPROACH

4.1 INTRODUCTION

The essence of the last two chapters revolved around the meaning and legislative implementation of children's health service rights. One particular aspect of children's health rights was the focus of chapter 3, namely, the issue of consent. In light of the Children's Act 38 of 2005 which has already transformed current child law and will continue to do so once it becomes completely operational, chapter 3 considered implications of new consent provisions for children's health service rights. This chapter continues to probe the implications of the Children's Act, by considering a particular aspect of the issue around consent, namely, the status approach. This chapter is not concerned specifically with the practical problems and challenges which arises and will still arise from the operation of the consent provisions in the Children's Act as discussed in the previous chapter, but rather looks at a constitutional challenge or problem which could arise from the use of the status approach in the Act.

The status approach entails using age as a determining factor regulating children's ability to access health care services with or without parental or guardian assistance. As seen in chapter 3, much health care legislation as well as provisions in the Children's Act makes use of the status approach to grant children the right to consent to or refuse health care services on their own. This chapter will explore the constitutional impact of this approach in the Children's Act on children's health service rights.¹ This will be done by first,

¹ Please note that the term 'health service rights' is used to refer to the right to access health care services in section 27(1) and children's right to basic health care services in section 28(1)(c) of the Constitution. The reasons for this are the same as those set out in section 1.1 of Chapter 1 in this thesis.

considering and discussing arguments made in support of and arguments made against the use of the status approach. Secondly, an attempt will be made to test these and other arguments against the general limitations clause in section 36 of the Constitution. The purpose of the inquiry is to determine the strengths of the arguments on the status approach to withstand constitutional scrutiny in light of the allegations they contain. To this end the chapter is set out as follows, Section 4.2 will look at the arguments for and against the use of the status approach and Section 4.3 will apply these and other arguments to the general limitations clause in section 36(1). Section 4.4 will be an evaluation in terms of section 36 and will conclude the chapter.

4.2 THE STATUS APPROACH

One of the ways in which the state supervises how children exercise their health rights is through the inclusion of consent provisions in legislation regulating access to health care services. A common trend in consent laws globally is the imposition of ages of consent for children in order for them to access health care independently. This is essentially the status approach. What this chapter generally aims to do is to establish the impact of the use of this approach on children's health service rights. In order to establish the general impact of the use of this approach, it is necessary to get a broader understanding of general arguments in respect of this approach. To this end the section below will outline arguments in favour of and arguments against the use of this approach. This is done as a basis for the constitutional inquiry to follow in section 4.3.

The difference between this section and section 4.3 is that this section considers the use of the status approach in general and does so through reviewing arguments made in respect of this approach. As the discussion of these arguments progress it will be seen that certain allegations flow from them, which triggers the need for the evaluation to be done in section 4.3. Section 4.3 thus, takes an example of the use of the status approach from certain sections of the Children's Act and then uses the arguments advanced in this section together with other arguments to evaluate the constitutionality of this approach in those provisions of the Act.

4.2.1 Arguments in favour of the use of the status approach

Four main points emerge from the arguments in favour. Firstly, children below a certain age are presumed to be incompetent to consent and thus in law lack the capacity to consent. This presumption stems from the belief that most children are ignorant, irrational or unthinking beings² and that they are 'less secure about their identity and less autonomous than adults'.³ Generally, the law regards certain children as incapable of consenting to agreements because they are deemed not sufficiently mature enough to understand and respond to the consequences attached to them. In order to protect children against their own immaturity and their inability to make value judgments due to their lack of experience which could result in an inability to assess a particular situation,⁴ the law

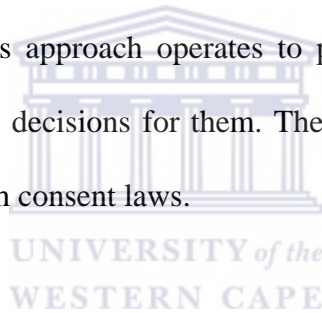
² P Alderson and M Goodwin (1993) *The International Journal of Children's Rights* 303 at 305.

³ G van Bueren (1998) 'Children's rights: balancing traditional values and cultural plurality' in G Douglass and L Sebba (eds) *Children's rights and traditional values* 21. Philosophers also label children as incompetents 'because they are suppose to be incapable of 'cognitive-complexity, to have unstable, transient values, no real concept of 'the good', of death, of their future, or of their likely future values.' See P Alderson (2005) 'In the genes or in the stars? children's competence to consent' in M Freeman *Children, medicine and the law* 551. See also J Kruger (2006) *THRHR* 436 at 439.

⁴ T Davel (2000) 'The status of children in South African Private Law' in Davel CJ (ed) *Introduction to Child Law in South Africa*, (2000) 1 at 20. See also H Kruger (2005) *Codicillus* 1 at 6.

creates safeguards through the use of consent laws. Adults are thus given decision making powers in respect of their children based on these classical liberal theories which deem children to have an irrational and dependent nature.⁵ This is the child protection approach supported by those against giving children decision making powers.⁶

Secondly, parents are primarily responsible for protecting their children. This responsibility is enumerated in the Constitution⁷ where it provides every child with the right to parental or alternative family care.⁸ This right places an obligation on parents to provide children the care and protection they need.⁹ This thus accords with health legislation requiring the parents to consent before any treatment is administered to their children. In this way the status approach operates to protect younger children and to allow for their parents to make decisions for them. The child's right to parental care is thus given effect to through such consent laws.



Thirdly, South Africa has ratified the Convention on the Rights of the Child (CRC)¹⁰ in 1995. The CRC provides that, the state has to respect the responsibilities, rights and

⁵ C Breen (2006) *Age Discrimination and Children's Rights: Ensuring Equality and Acknowledging Difference* 4-5.

⁶ Ross argues that generally parental autonomy promotes the interests and goals of both the child and the parent and '[b]y deciding that the child's decision should be respected over the parent's decision, physicians are replacing the parents' judgment that the decision should be overridden with their judgment that the child's decision should be respected. To do so makes this less an issue of respecting the child's autonomy, and more about who knows what is best for the child' See L Ross (2006) 'Health care decision-making by children: Is it in their best interest?' In M Freeman (ed) *Children, medicine and the law* 487 at 490. This article considers various other reasons why children's decision making capacity should be limited.

⁷ Constitution of the Republic of South Africa Act 108 of 1996.

⁸ Section 28 (1)(b) of the Constitution.

⁹ *Government of the Republic of South Africa and Others v Grootboom and Others* 2001 (1) SA 46 (CC) para 77-78.

¹⁰ Convention on the Rights of the Child (CRC), Adopted and opened for signature, ratification and accession by General Assembly resolution 44/25 of 20 November 1989, entry into force 2 September 1990.

duties of parents and when applicable members of the extended family or community.¹¹ This includes the parents' right to make decisions which are in the best interest of the child, such as decisions relating to the child's health. Furthermore, parents and family have a right to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of rights recognised in the Convention. Thus legislatures also give effect to this right by requiring parental or guardian's assistance when children have to exercise their health service rights.

Finally, there appears to be a consensus 'that the age limit must be drawn somewhere, and that legislators and courts are not unreasonable in setting an average age requirement where a particular function is concerned, as long as the age set is not completely out of touch with custom and mores'.¹² It is unclear what this consensus is based on but one basis for it is possibly the certainty it gives health care professionals to know who is able in terms of the law to consent to treatment without parental assistance.¹³

Thus the main arguments in favour of using this approach can be summed up as follows: children's need for protection, their right to parental care and possibly the need to create certainty for health care workers to know which children can consent to treatment without parental or guardians' assistance. Thus this approach opens the door for young persons who have reached the legal age of consent to be able to access health care services without the need for parental assistance (if they have the competence to consent).

¹¹ Art 5 of CRC.

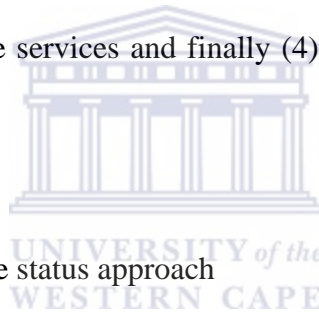
¹² H Kruger above note 4 at 3.

¹³ J Sloth-Nielsen (2007) 'Protection of children' in C Davel and A Skelton (eds) *Commentary on the Children's Act 7-1* at 7-31.

This protection approach also absolves children below a certain age from the responsibility that goes along with giving consent and places it on adults who are likely to be in a better position to take on the responsibility of consenting. Furthermore, if there is certainty about who is able to consent and who is not, then health practitioners should not be able to turn away children capable of consenting to services on the grounds that their parents need to be present.

4.2.2 Arguments against the use of the status approach

These arguments are set out by considering four points; (1) academic opinion on the status approach, (2) practical problems with the approach, (3) non use of the status approach for certain health care services and finally (4) will look at the status approach versus international law.



4.2.2.1 Academic opinion on the status approach

The status approach has been criticised as being arbitrary¹⁴ and in conflict with the notion of individuality and being in contrast with children's right to self-determination.¹⁵ Some writers have declared that '...if children are defined by their incompetence, ignorance and folly, then 'children's rights' is essentially a contradictory term.'¹⁶ Others contend further that '[s]ince maturation is a process that will necessarily vary from individual to individual, to adopt one particular age...as the benchmark of maturity in all persons is

¹⁴ See M Brazier and C Bridge (2005) 'Coercion or caring: analysing adolescent autonomy' in M Freeman (ed) *Children, medicine and the law* 84 at 88.

¹⁵ I Kennedy (1988) *Treat me right: essays in medical law and ethics* 57.

¹⁶ P Alderson and M Goodwin above note 2 at 308.

clearly untenable¹⁷ and that '[a]ny specific finding about age...should not be regarded as sacrosanct but as no more than a rule of thumb guide'.¹⁸

4.2.2.2 Problems in practice

When a situation arises in practice where a child, below the age of consent, and in need of health care services goes to or is taken to a health facility unaccompanied by a parent or a guardian the law requires the health provider to respond in a specific way. The health provider must either ask the minor to return with his or her parent before the health service is provided or in more serious cases, but not an emergency, the health provider is required to inquire as to the whereabouts of a parent or guardian and to attempt to contact them.¹⁹ As a result, for example, '[m]any surgeries have been delayed and cancelled while a hospital's risk management department, a child's social worker, and the ... courts try to identify [and get hold of] a legal representative who can consent to the child's surgery.'²⁰

¹⁷Kennedy above note 15. This is also accepted by Ngwena when he states that '...developmentally childhood is not a static condition' See C Ngwena (1996) *Acta Juridica* 132 at 133. See also H Kruger above note 4 at page 5 where she notes that '[c]hildhood is a process of continuous change, which takes place as the child develops from newborn to adolescents'.

¹⁸ Ngwena above note 17 at 139.

¹⁹ In its review of the Child Care Act the South African Law Commission (as they were called then) identified several problems experienced by practitioners in applying the consent provisions in the Child Care Act, one of them related to most practitioners, particularly those working in hospitals reporting problems with obtaining consent for non-emergency procedures from parents or guardians who lived far from the child. See South African Law Commission 'Review of the Child Care Act' Discussion Paper 103 (Project 110) 2002 453 at 466.

²⁰ See A Bittinger (2006) *Florida Bar Journal* 24. Retrieved 12 November 2007, from Westlaw online database. This is also the case in South Africa where the requirement of obtaining ministerial consent has led to delays and /or cancellations of the intended surgery or institution of appropriate therapy. See J Karpelowsky and H Rode (2006) *SAMJ* 505 at 505.

The problem is worse when there are no parents or guardians able to consent to the treatment.²¹ In these cases problems are created by the law requiring the practitioner to jump through many hoops to get the necessary consent, even when the patient is mature enough to give the necessary consent. The argument here is not that the law should not have those procedural requirements which the health provider must fulfil in order get the necessary consent. Rather the argument is that the law should create the opportunity for a mature minor to consent to treatment despite his or her age and this would minimise the health provider having to go through so much trouble to get consent from someone else in cases where the patient is in fact capable of consenting.

4.2.2.3 Non use of status approach for certain health services: contradictions in law?

²¹ The problems created by the Child Care Act provisions regarding consent are clearly illustrated by the case of *Ex Parte application of Nigel Redman N.O* Case No 14083/2003 and *Ex Parte application of Nigel Redman N.O* Case No 18476/2003 WLD (unreported). This case involved an urgent application by the Aids Law Project (ALP) to obtain consent from the High Court to provide antiretroviral therapy needed by four orphaned children with HIV/AIDS who had no parents. These children were below the age of 14 and needed parental or guardian consent to obtain medical treatment. The urgent health needs of the children necessitated the ALP to bypass the Minister of Social Development and go directly to High Court to get the required consent because the process of obtaining ministerial consent was found to be time consuming. The application was successful. This was followed by several requests made to the Minister to obtain consent to provide some forty children also needing antiretroviral treatment and HIV testing and who could not get parental consent. The Minister only consented to the treatment of five children. The ALP had to lodge another urgent application to the High Court to get consent for the rest of the children. The application succeeded as well. Although the applications were successful the case illustrated various problems arising from attempts to comply with the consent provisions of the Child Care Act when parental consent is unobtainable. Particular difficulties include the following:

1. Applications to the High Court proved to be time consuming, causing delays to important medical treatment for children.
2. The reach of the Courts' decision was limited because the legal circumstances of other children in South Africa in the same situation remained unchanged.
3. Fresh applications have to be made to the Court or new requests to the Minister have to be made for consents on every occasion.
4. To institute a High Court application every time a child without a legal guardian or parent requires HIV testing or treatment is costly, prohibitive, impractical and inconvenient.

See L Gerntholtz. South Africa: Safeguarding Children's Rights to Medical Care. Submission on the Children's Bill. Portfolio Committee on Social Development National Assembly, 27 July 2004. Available at http://hrw.org/english/docs/2004/07/27/safric9150_txt.htm [accessed 23 October 2007].

In short, this argument entails the use of the status approach in cases involving for example medical treatment, surgery and HIV-testing but the non-use of this approach for other health care services such as a termination of pregnancy. The argument is based on questioning the legislative choice to use age as a determinant for children needing to access medical treatment and HIV testing when it is not a determinant for pregnant girls needing abortions. The argument is fully discussed below.

The legislature chose not to use the status approach for girls needing to terminate their pregnancies. In terms of the Choice on Termination of Pregnancy Act 92 Of 1996 a girl of any age has a right to terminate her pregnancy. This choice by the legislature was considered in the case of *Christian Lawyers Association v Minister of Health and Others (Reproductive Health Alliance as Amicus Curiae)*.²² The court found justification for this approach based on *inter alia*, the fact that by not prescribing age limitations for girls needing to access termination of pregnancy services the provision ‘prevents frustration of a constitutional right when the minor is in fact emotionally and intellectually able to give informed consent to the procedure.’²³ Furthermore, the court emphasized the constitutional recognition of the right to individual self-determination²⁴ and held that the plaintiff’s approach of setting age limits for girls to access abortion services was a rigid approach to maturity which failed to accommodate individual difference.²⁵ In the end the Court found that the Act required the women to give informed consent and that this would determine her ability to access a termination of pregnancy no matter what her age

²² *Christian Lawyers Association v Minister of Health and Others (Reproductive Health Alliance as Amicus Curiae)* 2005 (1) SA 509 (T).

²³ Above note 22 at 517.

²⁴ Above note 22 at 518.

²⁵ Above note 24.

was. The approach taken by the legislature was found to be consistent with the Constitution.

It is submitted that the very arguments used to justify the legislatures' decision in the *Christian Lawyers* case not to use the status approach for children's termination of pregnancy can also be used to argue for non-use of this approach when it comes to other health care services for children.

4.2.2.4 The status approach and international law

The United Nations Convention on the Rights of the Child (CRC) has been ratified by South Africa and its provisions are thus binding on the state.²⁶ Section 28 is based on the provisions and principles of the CRC which has become the international standard against which to measure legislation and policies.²⁷ Some of the articles contained in the CRC seem to support arguments against the use of the status approach when it comes to health care services for children. The CRC makes provision for recognizing the evolving capacity of the child when the child exercises his or her rights.²⁸ Consent laws prescribing rigid age restrictions fail to recognise this evolving capacity of the child. Brazier and Bridge, note that '[f]ocusing on chronological age alone ignores the development of that individual and flies in the face of notions of evolving autonomy.'²⁹ The maturity test is applied to children who have the capacity to consent but does not

²⁶ Convention on the Rights of the Child above note 10. Ratified by South Africa in June 1995.

²⁷ *S v M* Case CCT 53/06 September 2007 (unreported) at para 16.

²⁸ Article 5.

²⁹ See Brazier and Bridge above note 14 at 26.

come into play for children below the age of consent and for that reason it is argued that age being the determining factor ignores evolving capacity of the child.

The CRC also provides children with the right to participate in decisions affecting them, this includes decisions in respect of their well being of which health is a component.³⁰ This particular right is extremely important when it comes to children accessing health care services because the notion of consent is embedded in the right to participate in decisions affecting the child's life. The amount of weight to be given to the child's views (besides depending on the child's age and maturity) depends on the 'imminent and heavy' consequences which the decision would have on the child.³¹ Article 12 also implies that 'although adults have the duty to protect children from ill-treatment, children are [also] protected...by giving [them] power to consent to and challenge decisions which affects their lives...'³² Although article 12 only gives the child the right to be able to express his views and does not provide the child the right to actually consent, the status approach also negatively affects this right in that the views of children below the age of consent are generally ignored because their immaturity is assumed.

The arguments against the status approach can be summed up in four points: (1) The status approach does not recognise the individuality of each child because it is based on assumptions of immaturity. (2) Practical problems experienced by health care providers when they have to trace parents or guardians or make court applications first before

³⁰ Art 12 of CRC reads: '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.'

³¹ M Lucker-Babel (1995) *International Journal on Children's Rights* 391 at 399.

³² Van Bueren above note 3 at 21.

supplying a health care service to a child could be alleviated where a child patients' maturity could allow him or her to consent to the necessary health care service despite his or her age. (3) In light of the Termination of Pregnancy Act which allows girls of any age to access abortion services with the main determinant being the girls' ability to give informed consent rather than age there is no reason why this approach should not also apply to other health care services for children. (4) The status approach contravenes provisions of the CRC in that it fails to recognise the evolving capacity of the child and does not adequately protect children below the age of consent of their right to express their views and to have those views be given due weight.

It must be noted that the arguments against the use of the status approach should not be construed to advance an absurd contention that all children should be given the right to consent regardless of their stage of development. The arguments against the status approach advance the notion that all children should be given the right to consent taking into account their stage of development.

4.3: TESTING THE CONSTITUTIONAL VALIDITY OF THE STATUS APPROACH

What would the possible finding of the Constitutional Court be if it was faced with a case in which a minor claimed that the status approach limited her health service rights in section 28(1)(c) and 27(1) of the Constitution and that the limitation cannot be justified in terms of the general limitations clause? This section attempts to answer this question by considering a hypothetical example of a case and applying arguments for and against the

status approach to the general limitations clause. Before embarking on this exercise one cannot ignore the issues surrounding the relationship between the general limitations clause and the internal limitations as found in section 27(2) which would apply to this hypothetical scenario.

4.3.1 Relationship between section 36 and internal limitations in section 27(2) of the Constitution

In the *Khosa* case the Court noted the difficulty in applying section 36 of the Constitution to the socio-economic rights in sections 26 and 27 of the Constitution.³³ It noted, without discussing this, that in a case where a court has found that the state failed the reasonableness test in section 27(2) or 26(2) that section 36 could only be relevant if ‘what is “reasonable” for the purposes of .. section [36], is different to what is “reasonable” for the purposes of sections 26 and 27.’³⁴ In *Jaftha*³⁵ the Court did not have a chance to elaborate on this although the applicants in that case also claimed that their right of access to housing was violated triggering the Court to undertake a section 36 inquiry. The difference with *Jaftha* was that the Court considered the negative obligations on the state in terms of section 26(1) and it was found that the obligations in 26(2) did not apply to the negative aspects of the rights to access housing. So the Court did not engage section 26(2) and the difficulty in applying this section to section 36 did not arise.

The Court in *Khosa* said that section 36 can only be relevant in a case involving breach of the state’s obligations in section 27 if the reasonableness inquiry in section 27(2) is

³³ *Khosa and Others v Minister of Social Development and Others* 2004 (6) SA 505 (CC) para 83.

³⁴ Above note 33.

³⁵ *Jaftha v Schoeman and Others Others* 2005 (2) SA 140 (CC).

different from the reasonableness inquiry in section 36. Although the Court did not take the matter further, some academics are of the view that the two inquiries are different,³⁶ but they also accept that the same contextual considerations are focused on in the two types of reviews.³⁷ In *Khosa* the Court was satisfied that even if the reasonableness review in 27(2) was different to reasonableness in section 36 the state's exclusion of permanent residents from the social security scheme was not reasonable or justifiable under section 36. This acceptance by the Court accords with the conclusion reached by Woolman and Botha that considering the socio-economic rights cases which the Court have dealt with thus far there appears to be no reason to think that there may be grounds for justification that the state could assert under section 36 that are unavailable to it under section 26(2) or section 27(2).³⁸ Rautenbach argues further that the way the factors in section 36 are also taken into account in the reasonableness review in section 27(2) suggests that it overlaps with the general limitations clause to such an extent that there

³⁶ Woolman and Botha notes a distinction between section 27(2) and 36(1) founded on the texts of these provisions. They note that the language of these two provisions indicate different ground of justification when these enquiries take place. 'Whereas section 27(2) appears to limit our considerations to those justifications related to the means required to realize the purpose of the right (eg, money) or the end of the right itself (eg, social security), [section] 36 tells us that we may cast our justificatory nets as far as the needs of an open and democratic society based on human dignity, equality and freedom will allow'. See S Woolman and H Botha (2007) 'Limitations' in S Woolman, T Roux and M Bishop *Constitutional law of South Africa, Student Edition* 34-1at 34-40. Illes notes the following differences between the reasonableness test in section 26(2) and the reasonableness inquiry in section 36 (1) first he states that reasonableness test as developed in *Grootboom* concerns *inter alia* issues like how and when the content of the right will be extended, 'the order in which the state plans to cater for those in need and the resources that the state has deployed towards realising its stated plan including the inter-governmental allocation of tasks and responsibilities'. Whereas section 27(2) reasonableness examines the states' plan for realising the right, section 36 reasonableness does not focus on the plan but examines the reasonableness of measures that limit rights. K Illes (2004) *SAJHR* 448 at 456. Bilchitz notes that the internal limitation is focused on a particular right: 'in this context, the right to have access to health care services. The enquiry requires us to consider whether, in the context of this *particular* right, and the competing priorities in relation to this *particular* right, the measures taken by the State are reasonable'. On the other hand a section 36 inquiry requires a comprehensive analysis of the right and the measures the state adopted by taking into account other rights and other interests involved. 'It allows for the consideration of legitimate government purposes other than those relating to the particular right that has been limited, and requires consideration of a measure's impact on society beyond the sphere of health care'. See D Bilchitz (2007) 'Health' in S Woolman, T Roux and M Bishop (eds) *Constitutional law of South Africa, Student Edition* 56A at 56A-16.

³⁷ Woolman and Botha above note 36 at 34-32.

³⁸ Above note 36 at 34-39.

seems to be no room for applying the general limitations clause after finding that the state could not justify its failure to meet its obligations in section 27(2).³⁹

The Court in *Khosa* focused on the reasonableness review in terms of section 27(2) rather than the general limitations clause because no arguments were made in respect of section 36. Iles criticises the approach taken by the court and argues that '[o]nce the Court admitted that it was not dealing with the content of the right but rather with access to the right, the internal limitations clause became irrelevant and the analysis should instead have centred around the justifiability of failing to provide access to certain groups in terms of the limitations clause'.⁴⁰

Whether or not the approach followed in *Khosa* was correct or not is not necessary to decide here. It is submitted that if it is accepted that there is a difference between section 27(2) inquiry and a section 36 inquiry, but that the same factors or contextual considerations are taken into account no matter which inquiry a court chooses to follow (depending on whether or not the applicant gives arguments relevant to a certain inquiry) and that the outcome would be the same either way, then it could be more a matter of choice between two inquiries and not so much a matter of reconciling the two approaches. If this is correct, Woolman and Botha argue that a court faced with going one way or the other is more likely to follow its sections 26(2) and 27(2) reasonableness

³⁹ I Rautenbach (2005) *TSAR* 627 at 653.

⁴⁰ K Iles above note 36 at 464.

review than to create ‘a meaningful allocation of analytical responsibilities between these sections and section 36’.⁴¹

In the hypothetical case to be analysed below, a different view is taken. It is assumed that the Court chose to undertake a section 36 inquiry instead of a section 27(2) reasonableness analysis and it is further assumed that the outcome would be the same whether or not the inquiry is done under section 27 or under section 36, thus a section 36 inquiry is preferred in this particular case as a matter of choice only. For the purposes of the case it is assumed further that the relevant provisions in the Children’s Act have come into operation.

4.3.2 Analysing the status approach under section 36

In what follows the status approach is evaluated in terms of the limitations clause. This is done in the context of a hypothetical scenario in which the status approach is challenged in the Constitutional Court. In this scenario an application is made by K a 10 year old minor alleging that her health service rights in sections 28(1)(c) and section 27(1)(a) are violated by the status approach as used in the Children’s Act 38 of 2005. In terms of section 129(2)and (3) of the Children’s Act children aged 12 who are mature can consent to medical treatment without parental assistance and those who are in need of surgery and also 12 years and older can also consent to such surgery but must also be assisted by their guardians or parents. K contends that these sections are unconstitutional to the extent that it prevents mature minors below the age of consent, such as herself, to access health care services like medical treatment and surgery on their own and further that the status

⁴¹ Woolman and Botha above note 36 at 34-31.

approach in general is unconstitutional when used in legislation aimed at fulfilling the right to access health care services and children's right to basic health care services. She contends further that this approach leads to mature minors below the age of consent being unable to access health care services on their own whereas those above that age can do so without parental assistance and that this amounts to unfair discrimination on the basis of age and on the basis of health care needs seeing that mature girls of any age can consent to a termination of pregnancy without involving their parents or guardians and that this is in contravention of section 9 of the Constitution. Finally, it is contended that these limitations cannot be justified in terms of section 36 of the Constitutions. For ease of reference to the hypothetical scenario it will also be referred to as 'the K matter'.

These contentions must undergo a limitation analysis so as to establish their validity. When it comes to an investigation into the limitation of rights a two stage enquiry ensues. At the first stage the question is asked whether there was an actual limitation of the relevant right. If the answer is positive to the first question then the second stage is triggered and the question asked there is whether the limitation can be justified or not.

The Limitations analysis:

4.3.2.1 Does section 129 subsections (2) and (3) and the use of the status approach in general limit children's health rights?

At this stage what needs to be determined is the scope of the right.⁴² The question is whether the law or conduct restricts an activity which falls within the protected scope of

⁴² K Iles (2007) *SAJHR* 23 at 71.

the right.⁴³ What the applicant in the K matter must show is that the ambit of the right covers the conduct which she seeks to protect.⁴⁴ The applicant in this case must thus show that accessing medical treatment and surgical operations are part of her health service rights in sections 27(1) and 28(1)(c) and that the sections in the Children's Act restricts her from enjoying these rights.

In *Grootboom*, *Treatment Action Campaign (TAC)*⁴⁵ and *Khosa* the Court found that the ambit of the right in section 27(1) and 26(1) must be determined by also considering section 27(2) and section 26(2). In *TAC* it was said that 'sections 27(1) and 27(2) must be read together as defining the scope of the positive rights that everyone has and the corresponding obligations on the state to respect, protect, promote and fulfil such rights. The rights conferred by sections 26(1) and 27(1) are to have 'access' to the services that the state is obliged to provide in terms of sections 26(2) and 27(2).⁴⁶

'Access' in the context of health care has been defined as 'a multidimensional concept that describes people's ability to use the necessary health care, immediately wherever they are'.⁴⁷ 'Accessibility to health care is concerned with the ability of a population to

⁴³ Above note 42. For an in depth discussion on what is meant by the term 'protected conduct' or 'protected interest' see also G van der Schyff (2005) *Limitation of rights: A study of the European Convention and the South African Bill of Rights* 31-40 and again from 91-104.

⁴⁴ Woolman and Botha above note 36 at 34-4.

⁴⁵ *Minister of Health and Others v Treatment Action Campaign and Others* (No 2) 2002 (5) SA 721 (CC)

⁴⁶ Above note 45 at para 39.

⁴⁷ N Bagheri, G Benwell and A Holt (2006) *Health Care & Informatics Review Online*. Available at <http://hcro.enigma.co.nz/website/index.cfm?fuseaction=articledisplay&FeatureID=010906> [Accessed 12 November 2007]

obtain a specific set of health services'.⁴⁸ In terms of section 28(1) (c) children have a right to basic health care services. Although section 28 does not mention the word 'access' it is still an element of the right to basic health care services. Thus, section 28 might not create a limited right of 'access' to health care services like section 27, but it includes in its broad form a right of children to be able to access basic health care services.

The Children's Act and its individual provisions are meant to give effect to children's health service rights. It cannot be denied that medical treatment and surgery are forms of health care services which are protected under the health service rights in section 28(1)(c) and section 27(1).⁴⁹ These rights entitle children to be provided with health care services⁵⁰, and they must thus be able to access those services. The state must facilitate this access by putting measures in place to assist children in accessing the necessary health care service.⁵¹ In *Jaftha* the Court found that if a measure permits a person to be deprived of existing access to housing then it limits the right protected in section 26.⁵²

The hypothetical scenario used here as a basis to analyse the status approach is however not concerned with the limitation of existing (albeit limited) enjoyment of health service rights but is rather concerned with the limitation of the full enjoyment of health rights,

⁴⁸ S Ebener, Z El Morjani, N Rav and M Black 'Physical Accessibility to health care: From Isotropy to Anisotropy'. Online at <http://www.gisdevelopment.net/magazine/years/2005/jun/care.htm> [Accessed 23 October 2007]

⁴⁹ See for example *Minister of Health and Another NO v New Clicks South Africa (PTY)TLD and Others (Treatment Action Campaign and Another as Amici Curiae)* 2006 (2) SA 311 (CC) at para 514 and *Minister of Health, KwaZulu-Natal v Soobramoney* 1998 (1) SA 765 (CC) at para 19.

⁵⁰ *Soobramoney* above note 49.

⁵¹ *Grootboom* above note 9 at para 93

⁵² *Jaftha* above note 35 at para 34.

like the *Khosa* matter. Quoting from *Grootboom* where it was held that subsection 1 of section 26 places a negative obligation on the state to desist from preventing or impairing the right of access to adequate housing, the Court in *Khosa* held that the same applies to section 27 as well.⁵³ This means that the state should not prevent or impair the right to access health care services.

What is clear from the above is that the ability to access a health care service is a protected activity of the right to health care services in both sections 27 and 28 of the Constitution. The state is obliged not to prevent children from accessing such services because ‘rights [which] describe the duties of those bound by the rights are *de facto* limited when these duties are not observed’.⁵⁴ Section 129 limits the health service rights of mature minors below the age of consent in the following way. The section interferes⁵⁵ with their ability to access services in the same way as those above the age of consent because they may only access the services if they are accompanied by a parent or guardian. Thus their ability to access the necessary services is conditioned and unless the condition is complied with they cannot obtain the health care service. Even if they are not comfortable with the idea of involving their parents in a particular situation the health service will be refused and they will be turned away if they are not with their parents. In such a situation access to the health service is completely denied preventing the factually mature minor from enjoying an activity which falls within the scope of the right, namely, the ability to access a health care service.

⁵³ *Khosa* above note 33 para 109.

⁵⁴ Rautenbach above note 39 at 629.

⁵⁵ ‘An interference is described more closely as a state of affairs, be it occasioned by an action or in-action, which causes the exercise of the protected conduct or interests to be impaired or hindered.’ Van der Schyff above note 43 at 41.

Do the sections unfairly discriminate against mature minors below the age of consent?

The achievement of equality and the advancement of human rights and freedoms are part of the founding values of South Africa's democratic state.⁵⁶ Section 9 of the Constitution promotes the value of equality and prohibits unfair discrimination. The section reads as follows:

9: Equality

- (1) Everyone is equal before the law and has the right to equal protection and benefit of the law.
- (2) Equality includes the full and equal enjoyment of all rights and freedoms. To promote the achievement of equality, legislative and other measures designed to protect or advance persons, or categories of persons, disadvantaged by unfair discrimination may be taken.
- (3) 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.
- (4) No person may unfairly discriminate directly or indirectly against anyone on one or more grounds in terms of subsection (3). National legislation must be enacted to prevent or prohibit unfair discrimination.
- (5) Discrimination on one or more of the grounds listed in subsection (3) is unfair unless it is established that the discrimination is fair.

⁵⁶ Section 1 of the Constitution.

In the case before the Court the applicant makes claims of unfair discrimination on two grounds, that of age and that of health care needs. In the first instance the applicant contends that the provisions of the Children's Act discriminate against mature minors on the basis of age because children above the age of consent are treated differently to those below that age and that it is this different treatment that results in mature minors below the age of consent not enjoying their right to access health care services fully and equally to those children above the age of consent. Secondly the applicant claims that seeing that the legislature does not use age restrictions when it comes to a termination of pregnancy for girls but sets such age restrictions for health services like medical treatment and surgery this, too, amounts to unfair discrimination on the basis of health care needs. The factors to be considered when someone alleges unfair discrimination are dealt with first.

In *Harksen v Lane*⁵⁷ the Court set out the criteria for determining unfair discrimination. Four questions must be asked, namely, (1) is there a differentiation? (2) does the differentiation amount to discrimination, (3) is the differentiation unfair? and (4) if it is unfair discrimination because it is on a listed ground then the question that must still be answered is whether it is in fact unfair discrimination.

4.3.2.2 Determining differentiation

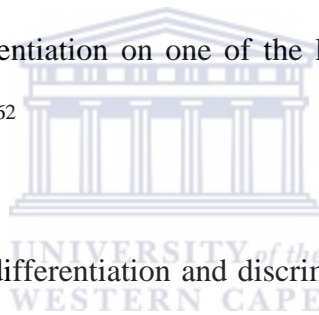
Here the Court has to look at whether the provision differentiates between people or categories of people and if the differentiation bears a rational connection to a legitimate government purpose.⁵⁸ In *Prinsloo v Van der Linde*,⁵⁹ the Court explained that:

⁵⁷ *Harksen v Lane No and Others* 1998 (1) SA 300 (CC) para 53.

⁵⁸ I Currie and J de Waal (2005) *The Bill of Rights handbook* 239.

In regard to mere differentiation the constitutional State is expected to act in a rational manner. It should not regulate in an arbitrary manner or manifest "naked preferences" that serve no legitimate governmental purpose, for that would be inconsistent with the rule of law and the fundamental premises of the constitutional State.⁶⁰

Thus, the differentiation will amount to discrimination if it is arbitrary, irrational or it manifests a 'naked preference'. However, this is not the only way to establish the presence of discrimination when it comes to differentiation. Even if the differentiation does serve a non arbitrary or rational government purpose it can still amount to discrimination⁶¹ because differentiation on one of the listed grounds set out in section 9(3) amounts to discrimination.⁶²



The distinction between mere differentiation and discrimination is very important to the applicants' second claim of unfair discrimination and is considered first. What the applicant in the K matter basically complains of is that the legislature treats children under the age of consent (i.e 12) worse when it comes to their health needs compared to the way it treats girls needing a termination of pregnancy which is also a health need. It can be accepted that there is differential treatment when it comes to girls needing

⁵⁹ *Prinsloo v Van der Linde and Another* 1997 (3) SA 1012 (CC)

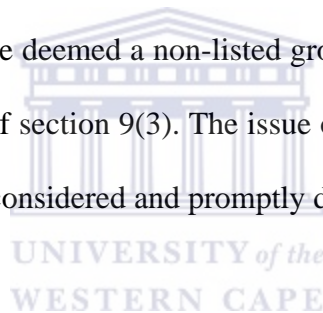
⁶⁰ Above note 59 at para 23.

⁶¹ *Harksen* above note 57 at para 53.

⁶² *Harksen* above note 57 at para 46. Currie and de Waal explain that 'discrimination is differentiation on illegitimate grounds' whether listed in section 9(3) or analogous to those listed in section 9(3). See Currie and de Waal above note 58 at 243-244. In *Harksen* the Court also established that 'There will be discrimination on an unspecified ground if it is based on attributes or characteristics which have the potential to impair the fundamental dignity of persons as human beings, or to affect them adversely in a comparably serious manner.' *Harksen* above note 57 at para 46. However discrimination on an unspecified ground is not relevant to this case and thus needs no further consideration.

abortions. Those girls could get such services no matter what their age without involving their parents if they are competent to consent, compared to how children needing other health care services are treated, in that besides having to pass the maturity test, they also have to be of a certain age or older in order to consent to health services without the need to get parental or guardian assistance.

The issue here is not differentiation on the ground of age (which is discussed later) but whether the differentiation regarding different health needs, for example surgery, medical treatment etc can also amount to discrimination. Based on the conclusion reached in this regard it is unnecessary to determine whether differentiation based on 'health needs' as opposed to 'health status' can be deemed a non-listed ground which could still amount to unfair discrimination in terms of section 9(3). The issue of possible discrimination on the basis of health needs is briefly considered and promptly dismissed below.



The Equality Act⁶³ defines discrimination as

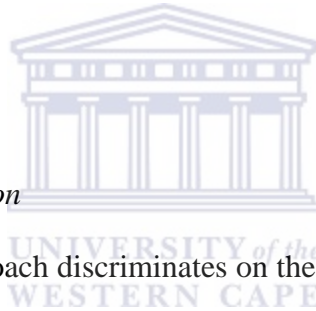
‘...any act or omission, including a policy, law, rule, practice, condition or situation which directly or indirectly-

- (a) imposes burdens, obligations or disadvantages on; or
- (b) withholds benefits, opportunities or advantages from, any person on one or more of the prohibited grounds..’

The issue of disadvantage or prejudice as a result of a law plays an important role in establishing discrimination. In *Hugo* the Court held that ‘the advantage of releasing

⁶³ Act 4 of 2000.

mothers of small children, through a presidential pardon, which was not afforded to fathers of small children was enough to establish discrimination within the context of s 8(2) of the interim Constitution'.⁶⁴ Similarly the Court in *Minister of Home Affairs v Fourie and Others* held that the exclusion of same sex couples from the benefits of marriage law constituted a denial of their right to equal protection and benefit of the law and this was as a result of prolonged discrimination based on their sexual orientation.⁶⁵ It is clear in the case at hand that the disadvantages alleged to be suffered as a result of the status approach flows directly from the age restrictions the legislature chose to put in place and does not flow from her specific health needs. For this reason the focus must be on the claim of discrimination on the basis of age and not the alleged discrimination on health needs.



4.3.2.3 Age-based Discrimination

It is alleged that the status approach discriminates on the grounds of age. Returning to the *Harksen* test for discrimination the questions to be asked is whether there is differentiation and if this differentiation amounts to discrimination.

The relevant parts of section 129 of the Children's Act are set out here again for convenience;

- 129(2) 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

⁶⁴ *President of the Republic of South Africa v Hugo* 1997(4) SA 1 (CC) para 33.

⁶⁵ *Minister of Home Affairs v Fourie* 2006 (1) SA 530 para 75-76.

- (b) the child is of sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications of the treatment.
- (3) A child may consent to the performance of a surgical operation on him or her or his or her child if—
- (a) the child is over the age of 12 years; and
- (b) the child is of sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications of the surgical operation; and
- (c) the child is duly assisted by his or her parent or guardian.
- (4) 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.
- (5) The parent or guardian of a child may, subject to section 31, consent to a surgical operation on 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 operation.

These provisions indicate that when a child is older than 12 and mature enough to consent then he or she can give the necessary consent on their own without assistance from parents or guardians, but when it comes to surgical operations the child must be assisted by a parent. The question on whether the child's right to consent to surgery depends on whether or not he or she has been duly assisted has been considered

somewhere else⁶⁶ and is not relevant here. It is clear that different rules apply regarding consent by children who need medical treatment or surgery and the different rules depend on the age of the child. These different procedures is a direct result of the law treating children above the age of consent different-their capacity to consent only depend on their maturity-to those below the age of consent-they lack capacity to consent despite their maturity. Thus differentiation has been established.

As said before, the Court held in *Harksen* that when there is differentiation on a ground listed in section 9(3) of the Constitution then discrimination is also established. Section 9(3) prohibits discrimination on the ground of age⁶⁷ and thus the fact that section 129 differentiates between children above 12 and children below 12 years of age it is found that there is discrimination.

4.3.2.4 Unfair discrimination

Section 9(5) of the equality clause creates a rebuttable presumption that the discrimination is unfair if it is based on a listed ground as set out in 9(3).⁶⁸ Thus in this case the discrimination resulting from section 129 is presumed to be unfair unless proven otherwise. The state has to prove that the discrimination is not unfair.⁶⁹ In *Hugo* it was established that

⁶⁶ See chapter 3 of this thesis.

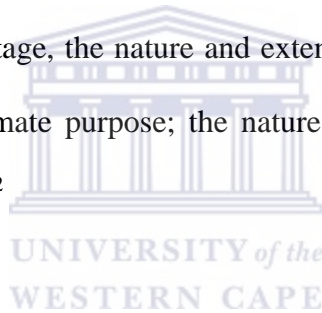
⁶⁷ The Equality Act defines 'age' as follows: 'age' includes the conditions of disadvantage and vulnerability suffered by persons on the basis of their age. See section 1 of the Act above note 63.

⁶⁸ 'even in cases of discrimination on the grounds specified in section 8(2), which by virtue of section 8(4) are presumed to constitute unfair discrimination, it is possible to rebut the presumption and establish that the discrimination is not unfair' *Harksen v Lane* above note 57 para 45

⁶⁹ Section 13(2) (a) of the Equality Act above note 63.

‘We need, therefore, to develop a concept of unfair discrimination which recognises 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’.⁷⁰

Unfair discrimination is determined by looking at the impact of the discrimination on the person discriminated against.⁷¹ To determine the impact of the discrimination the following factors can be considered, the position of the complainant in society and whether he or she suffers from patterns of disadvantage or belongs to a group that suffers from such patterns of disadvantage, the nature and extent of the discrimination; whether the discrimination has a legitimate purpose; the nature of the interest which has been affected by the discrimination.⁷²



These factors are strikingly similar to the factors a court considers in the section 36 analysis of the reasonableness and justifiability of a law limiting a right. Having regard to this the arguments advanced here will not all be repeated when the latter exercise is undertaken if it is found that the discrimination is indeed unfair.

In this case (the K matter) the discrimination is directed at very young children. We are not concerned with infants whose level of maturity will not allow them to understand the

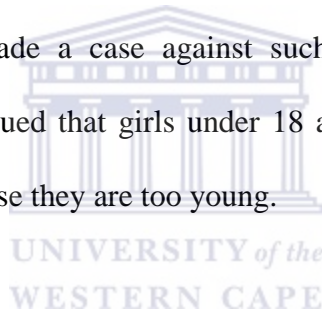
⁷⁰ *Hugo* above note 64 at para 41

⁷¹ *Khosa* above note 33 para 72.

⁷² *Hugo* above note 64 at para 47, *Harksen* above note 57 at para 51, *Khosa* Id and the Equality Act above note 63 section 14 (3)

benefits created by the Children's Act but with adolescents who have reached a stage of development which does allow them to be aware of and use their rights contained in the Constitution. This is the group of children in the position of the applicant for which we have to determine what impact the discrimination has on them.⁷³ Children in general are a vulnerable group in society because they are part of a minority. They are dependent on adults for almost everything that they need in order to reach a stage of adulthood where they could be released from that state of dependence.

However this dependent nature of children does not make them all irrational and immature beings incapable of making important decisions concerning their lives. In fact the legislature successfully made a case against such assumptions in the *Christian Lawyers* case where it was argued that girls under 18 are incapable of consenting to a termination of pregnancy because they are too young.



In the *Fourie* case the Court found that the more vulnerable the group affected by the discrimination the more likely is it that such discrimination will be deemed unfair and that vulnerability also depends on patterns of stereotyping.⁷⁴ The position of children can be equated with that of women centuries ago when women were considered to lack the ability to make decisions because of their gender and their husbands had all the decision making powers. Another stereotype applied to women by society because of their gender was that they were mainly responsible for the upbringing of children and were thus not

⁷³ The Constitutional Court has on many occasions considered the position of people who would be in the same position as the applicant but who are not party to the proceedings. See minority judgment in *Masiya v Director of Public Prosecutions, Pretoria and Another (Centre for Applied Legal Studies and Another, Amici Curiae)* 2007 (5) SA (CC)

⁷⁴ *Minister of Home Affairs v Fourie* above note 65 at para 50.

considered to have equal rights with husbands to seek and be employed. In *Hugo* the Court found that '[t]o use the generalisation that women bear a greater proportion of the burdens of child rearing for justifying treatment that deprives women of benefits or advantages or imposes disadvantages upon them would clearly, therefore, be unfair'.⁷⁵ Cannot the same views apply to children who are assumed immature and are thus deprived of societal and constitutional benefits like respect for autonomy?⁷⁶ It is a presumed characteristic of young children that they are incapable of making informed decisions and in the *Fourie* case it was held that '[s]ome minorities are visible, and suffer discrimination on the basis of presumed characteristics of the group with which they are identified'.⁷⁷

To determine whether the law has an unfair impact on the complainant the extent to which the discrimination impairs the right of the complainant must also be considered.⁷⁸ This impact inquiry can be done by looking at the advantages and disadvantages which stem from the provision, in this case the advantages of section 129 of the Children's Act in relation to the right to access health care services should thus be considered. In other words the question is really what benefits does the right to access health care services provide mature minors (and everyone else) and what disadvantages would mature minors below the age of consent in section 129 of the Children's Act suffer if they are excluded from the full benefits of this right?⁷⁹

⁷⁵ *Hugo* above note 64 at para 39:

⁷⁶ 'Child liberationists argue that children are the last oppressed group in society' See Ross above note 6 at 489.

⁷⁷ *Minister of Home Affairs v Fourie* above note 65 at para 77

⁷⁸ Currie and de Waal above note 58 at 245.

⁷⁹ Examples of cases where the Court considered the impact that the exclusion had on the individuals who were excluded from certain provisions. *Satchwell v President of the Republic of South Africa and Another*

The Equality Act defines equality as follows:

‘equality’ includes the full and equal enjoyment of rights and freedoms as contemplated in the Constitution and includes de jure and de facto equality and also equality in terms of outcomes’⁸⁰

In the context of this case the full enjoyment of health service rights means not having that right being interfered with by legislation. The right is interfered with here to the extent that the assumption of immaturity operates against a minor who is in fact mature who will need to at all times (until the age of consent is reached) be assisted by a parent or adult when she or he seeks medical treatment. The problem arises where the minor may not want to have the parent present for example if she needs treatment for an STD or STI but is below the age of consent for such treatment (disregarding for a moment that she is below the legal age to consent to having sex in the first place) so would not have a choice but to involve a parent or guardian. The mature minor above the age of consent is advantaged in that she would be able to access the services without having to disclose her sex related infection to a parent.

In another instance where a minor suffers from something more serious and she or he is accompanied by a parent but the minor disagrees with the decision of the parent if for example the parent wants to refuse treatment being advised by the health provider. In such a case the health practitioner will be forced to do what the parent says or make

2002 (6) SA 1 (CC) (2002 (9) BCLR 986); *Du Toit and Another v Minister of Welfare and Population Development and Others (Lesbian and Gay Equality Project as Amicus Curiae)* 2003 (2) SA 198 (CC), *Hugo* above note 64.

⁸⁰ Above note 63, Section 1.

application for ministerial or court ordered consent. The minor's access to the treatment could be denied or delayed depending on what the practitioner would choose to do, but if the minor was mature enough to make the decision then the delay or denial could have been avoided. The minor's maturity does not even come into the picture where she or he is below the age of consent because immaturity is assumed by operation of consent laws.

The advantage that the approach has for children above the age of consent is also clear when one considers section 13 of the Children's Act. This section gives every child the right to access information regarding his or her health status and regarding treatment for his or her health status. Take for example a situation where a child below the age of consent goes to a clinic with a parent for some or the other blood test (besides one for an HIV test) that child will not be able to get the results of the test without a parent so his right to access information regarding his health status will be impaired not to mention his right to privacy. If that same child does show up at the clinic with a parent and receives information regarding his health status and possible treatment which he might need the child cannot act on the information given by for example consenting to or rejecting the treatment proposed because the parent has decision making power. Given that section 13 requires the information to be given to the child in a manner which the child will understand the child should then also be able to understand the consequences of decisions made in accordance with the information being provided. The minor above the age of consent will be able to act on the information given if she is mature and understand it and if a parent for example disagrees with the minor's decision that parent might be able to

take the matter to court but the provisions of the Children's Act does not seem to give the parent the right to overrule the decision of a mature child who is over the age of consent. The state's primary aim for setting age limitations is to protect young children who do not understand the implications of giving consent. Actual understanding of the consequences of one's decision is part of the requirement for giving informed consent. The question is whether the criterion used by the legislature to achieve its objective results in unfair discrimination. The Court in *Khosa* held that '[t]he fact that the differentiation between citizens and non-citizens may have a rational basis does not mean that it is not an unfairly discriminatory criterion to use in the allocation of benefits'.⁸¹ The legislature wants to give effect to children's health service rights that is why section 129 is in the Children's Act in the first place, but the criterion it uses to do so, namely, setting age limitation results in mature minors below that age being disadvantaged.

The right to access health care services is integral not only to the right to dignity and equality but also to the idea of self-determination and autonomy.⁸² Presumptions of immaturity do not respect individuality and the right to self-determination. South Africa also has international obligations to promote equality and to prohibit unfair discrimination. The Committee on the Rights of the Child responsible for interpreting the provisions of the Convention on the Rights of the Child (which has been ratified by South Africa) produced a General Comment regarding adolescent health.⁸³ In terms of this General Comment the Committee notes that '[h]ealth facilities, goods and services

⁸¹ *Khosa* above note 33 at para 68.

⁸² C Ngwenya (2005) 'Rights concerning health' in D Brand and C Heyns (eds) *Socio-Economic Rights in South Africa* 107 at 131.

⁸³ Committee on the Rights of the Child: General Comment No. 4. (2003) Adolescent health and development in the context of the Convention on the Rights of the Child. CRC/GS/2003/4.

should be known and easily accessible (economically, physically and socially) to all adolescents without discrimination'.⁸⁴ The health service rights in the Constitution are not guaranteed to the extent that the person exercising the right must be of a certain age. The right to freedom and security of the person which is closely related to health service rights gives everyone the right to have control over his or her body and thus to make decisions regarding their body. In the exercise of this right too- age is not a precondition for exercising the right, thus 'age should not be mechanically related to decision-making capacity or maturity thereby denying equal rights to make decisions to those who are in fact able to do so'.⁸⁵

Having regard to the impact that the discrimination has on mature minors below the age of consent in that the presumption of immaturity result in them being disadvantaged as a result of a lack of respect for their autonomy it is found that the discrimination is unfair notwithstanding the importance of the purpose of the discrimination.

What must now be determined is whether the limitations placed on children's health rights as discovered above can be justified in terms of the general limitations clause.

4.3.2.5 Reasonable and justifiable limitation in an open and democratic society

Section 36

1. 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 an open

⁸⁴ Above note 83 at para 41.

⁸⁵ See, Breen above note 5 at 24 footnote 96.

and democratic society based on human dignity, equality and freedom, taking into account all relevant factors, including-

- (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 relation between the limitation and its purpose, and
- (e) less restrictive means to achieve the purpose.

2. Except as provided in subsection (1) or in any other provision of the Constitution, no law may limit any right entrenched in the Bill of Rights.

In conformity with the rule of law, section 36 authorises only a law 'of general application' to limit the rights in the Bill of Rights.⁸⁶ Legislation (including subordinate legislation), common law and customary law all fall under the concept of a 'law' of general application.⁸⁷ To be considered 'of general application' the 'law' must be clear, accessible, not arbitrary, and precise and apply equally and generally to all.⁸⁸

⁸⁶ *Dawood v Minister of Home Affairs; Shalabi & Another v Minister of Home Affairs; Thomas v Minister of Home Affairs* 2000 (3) (CC) at para 47, *Hugo* above note 64 at para 102.

⁸⁷ Currie and de Waal above note 58 at 169. See also Iles above note 42 at 76 and Woolman and Botha above note 36 at 34-51-52.

⁸⁸ Currie and de Waal above note 58 at 169 and 172. See also Woolman and Botha above note 36 at 34-48-50. For a broad discussion of the features and criteria of a law of general application Woolman and Botha also at 34-55-67. The majority in the *Hugo* case found that the exercise of presidential power did not constitute a 'law of general application'. In *S v Makwanyane and Another* 1995 (3) SA 391 (CC) it was contended that the section of the Criminal Procedure Act which allowed the death penalty did not constitute a law of general application because it did not apply uniformly throughout South Africa. The Court held that disparities between the legal orders in different parts of the country, as a result of the s 229 of the Constitution did not render the laws such that they are not of general application. See the judgment at para 32.

The Children's Act is legislation which is accessible and applies equally and generally to all children in South Africa and thus complies with the requirements of being a law of general application.

The law that is permitted to limit the right must be reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom. This means that 'the law in question [must] serve a constitutionally acceptable purpose and that there is sufficient proportionality between the harm done by the law...and the benefits it is designed to achieve....'⁸⁹ This is the proportionality enquiry.⁹⁰

In order to determine whether the law limiting the right is reasonable and justifiable in an open and democratic society section 36 gives five factors for a court to consider. These factors are not the only factors a court could consider and are also not a 'checklist of requirements'⁹¹ which a court must look out for when determining the reasonableness and justifiability of the law limiting the right. These and other factors must be balanced against each other. This balancing exercise requires a court to 'place the purpose, effects and importance of the infringing legislation on one side of the scales and the nature and effect of the infringement caused by the legislation on the other.'⁹² The factors set out in section 36 are explored below and applied to the facts of the K matter.

⁸⁹ Currie and de Waal above note 58 at 176.

⁹⁰ See *S v Makwanyane* above note 88 for more on the proportionality analysis.

⁹¹ Currie and de Waal above note 58 at 178. See also *Khosa* above note 33 at para 79.

⁹² *S v Bhulwana* 1996 (1) SA 388 (CC) para 18.

The *first* factor regarding the nature and importance⁹³ of the right requires firstly a determination of whether or not the right is capable of being limited⁹⁴ and how important the interest are which the right is aimed at protecting.⁹⁵ The importance of the right establishes what value a right has in an open and democratic society. The more important the right is to an open and democratic society based on dignity, equality and freedom the more compelling any justification for limiting that right must be.⁹⁶ In *Magajane v Chairperson, North West Gambling Board and Others* the Court held that this factor ‘focuses the court on the purpose of the right, the context that resulted in the right being enshrined in the Constitution and the seriousness of limiting the right’.⁹⁷

Socio-economic rights like any other rights in the Bill of Rights are capable of being limited. The case of *Soobramoney* is a great example of the fact that the right to access health care services can indeed be limited. Of course the fact that no rights are absolute and are all thus capable of being limited does not detract from the importance of the right.

Although the Constitutional Court has not been explicitly invited to consider in detail the importance of health service rights in a section 36 analysis, such importance can be deduced from their judgments. In *TAC* the court held that a government programme

⁹³ Although the phrase as found in section 36 does not include the word ‘importance’ this was added by the Court in *Makwanyane* (under the Interim Constitution’s section 33) and was subsequently applied by courts throughout the development of the limitations jurisprudence over the years. See Iles above note 42 at 77-78. Ackermann J made the point in *National Coalition for Gay and Lesbian Equality v D Minister of Justice* 1999 (1) SA 6 (CC) in para 34 that, although the section did not expressly mention the importance of the right infringed, ‘this is a factor which must of necessity be taken into account in any proportionality evaluation’.

⁹⁴ Iles above note 42 at 80.

⁹⁵ Rautenbach (2005) above note 39 at 631-634.

⁹⁶ Woolman and Botha above note 36 at 34-48-50. See also Van der Schyff above note 43 at 279.

⁹⁷ *Magajane v Chairperson, North West Gambling Board and Others* 2006(5) SA 250 (CC) at para 62.

which prevents HIV positive pregnant mothers from accessing the essential drug, nevirapine, could not withstand constitutional scrutiny, indicating how highly the right to access health services is valued when weighed against government actions affecting such rights. In *Minister of Health and Another NO v New Clicks South Africa*⁹⁸ and in *Soobramoney* it was established that the right to access health care services in section 27 included the right to medical treatment and the right to access affordable medicine and to this end the Court on those occasions illustrated the importance of accessing medical treatment and affordable medicine in light of the right to access health care services.

Furthermore, health service has great value for a democratic society based on dignity equality and freedom. In *Makwanyana* the Court held that the right to life and dignity are the most important of all human rights, and the source of all other personal rights in the Bill of Rights.⁹⁹ In *Jaftha* the Court held further that claims based on socio-economic rights must necessarily engage the right to dignity.¹⁰⁰ The right to access health care services as a socio-economic right is thus a component of the right to dignity. Health service rights naturally engage the right to human dignity when one considers how health services in the past were provided along racial lines and how the majority in this country were turned away and refused health care services simply because they were not considered worthy to be provided such services. Because their dignity was not respected their right to access health care services were not acknowledged. Section 27(1) and 28(1)(c) which provides for the protection of health care service rights aims to rectify

⁹⁸ *Minister of Health and Another NO v New Clicks South Africa (PTY)TLD and Others (Treatment Action Campaign and Another as Amici Curiae)* 2006 (2) SA 311 (CC).

⁹⁹ *Makwanyana* above note 88 para 144.

¹⁰⁰ *Jaftha* above note 35 at para 21. See also *Grootboom* above note 9 at para 83 where the relationship between the right to access housing and the right to dignity is established.

those injustices and accords with the intention of the Constitution to ‘improve the quality of life of all citizens and free the potential of each person’.¹⁰¹ The ability to access health care services thus affords all in South Africa the opportunity to live a dignified life. Thus given its connection to the right to dignity which is a core value under the Constitution, the importance of the health service rights in section 27(1) and 28(1)(c) is evident.¹⁰²

The *second* factor, the importance of the purpose of the limitation, entails considering the importance of the state and public interest to be served by the limitation.¹⁰³ In *Magajane* the Court indicated the importance of this factor when it noted that ‘the second factor... is crucial to the analysis, as it is clear that the Constitution does not regard the limitation of a constitutional right as justified unless there is a substantial state interest requiring the limitation’.¹⁰⁴

When considering this factor the purpose purported to be served by the limitation must be determined first and once this is established then the importance must be evaluated.¹⁰⁵

The objective of the provisions can be determined by considering the following; the overall purpose of the Act, the legislative history of the provision and the mischief it was

¹⁰¹ Preamble to the Constitution.

¹⁰² See *Khosa* above note 33 at para 114 where the Court held that the importance of the right to social assistance could not be gainsaid given the fact that it is a right which goes to one of the core values of our Constitution, namely, human dignity. See also *Currie and de Waal* above note 58 at 179.

¹⁰³ The limitation must serve a purpose that most people would regard as compellingly important. *Currie and de Waal* above note 58 at 164. One of the reasons why the Court in *S v Williams and Others* 1995(3) SA 632 (CC) found that the limitation of the right against cruel and inhumane punishment through juvenile whipping could not be justified in terms of the Constitution was because it held that no compelling interest was proved to justify the practice of juvenile whipping as a form of punishment, see para 91-92. ‘The purpose for which rights are limited usually consist of the protection or promotion of specific public interests, such as state security, public order, morality, public health and the administration of justice. The protection of the rights of others is also a purpose’ See *Rautenbach* above note 39 at 631-634.

¹⁰⁴ *Magajane* above note 97 at para 65.

¹⁰⁵ *Woolman and Botha* above note 36 at 34-73.

intended to address.¹⁰⁶ The importance of the purpose of the limitation can also be assessed by looking at whether the objective of the limitation is to advance constitutional values.¹⁰⁷ The purpose served by the limitation should be worthwhile and be geared at contributing to an open and democratic society based on human dignity, equality and freedom.¹⁰⁸

The legislature would argue that the use of the status approach in section 129 of the Children's Act is generally for the protection of children against their own immaturity and their inability to make value judgments.¹⁰⁹ Laws around the world set age limitations for accessing health care services without parental assistance. These age limitations protect children by placing the responsibility on adults to make important health decisions on behalf of the child. Furthermore, this responsibility to consent on behalf of the child is part of parents or guardian's constitutional obligations to provide parental care.

The purpose which section 129 serves can also be gathered from the overall objectives of the Children's Act. The objectives served by the Children's Act can be ascertained from its Preamble and its objects clause. The relevant part of the Preamble reads as follows:

'AND WHEREAS it is necessary to effect changes to existing laws relating to children in order to afford them the necessary protection and assistance so that

¹⁰⁶ Above note 105.

¹⁰⁷ Above note 105.

¹⁰⁸ Currie and de Waal above note 58 at 179. For examples of what the Courts has thus far considered to be important purposes in the limitation analysis see Currie and de Waal at 180-181 and Woolman and Botha above note 36 at 34-74-75.

¹⁰⁹ T Davel (2000) 'The status of children in South African Private Law' in Davel CJ (ed) *Introduction to Child Law in South Africa* 1 at 20. See also H Kruger above note 4 at 6.

they can fully assume their responsibilities within the community as well as that the child, for the full and harmonious development of his or her personality, should grow up in a family environment and in an atmosphere of happiness, love and understanding,’

The relevant parts of the Objects clause read as follows:

“Objects of Act

2. The objects of this Act are-

(a)

(b) to give effect to the following constitutional rights of children, namely-

(i) family care or parental care or appropriate alternative care when removed from the family environment;

.....

(i) generally to promote the protection, development and well-being of children’

What stands out from the above is that the Act aims to afford children the necessary protection, to ensure they receive parental assistance when needed and to promote their development and well-being. In setting age limitations through section 129, children below the age of 12 must be assisted by their parents when they need health care services. This affords them protection from their lack of experience and places decision making responsibility on a parent or a guardian. Their development and well-being are

also served by allowing them more time to gain experience in making important health care decisions.¹¹⁰

The legislature can also argue that children's health service rights must also be read with section 28(2) of the Constitution which states that the best interest of the child is of paramount importance in every matter concerning the child.¹¹¹ The standard of the best interest of the child is also made an objective of the Children's Act.¹¹² By giving effect to children's health service rights section 129 of the Children's Act is meant to serve the best interest of young children in general by protecting them from the responsibility of making health care decisions, the implications of which they don't fully understand due to their lack of development and experience.¹¹³

The objectives of section 129 read with the objectives of the Children's Act as a whole are thus to give effect to children's rights such as their right to parental care and more directly their right to basic health care services. The section also purports to serve the best interest of children by requiring them to be assisted by parents when their well-being are in issue and they need health care services thus affording them the protection they need given their vulnerability. These are very important objectives which certainly serves societal and state interest to protect the children of this country.

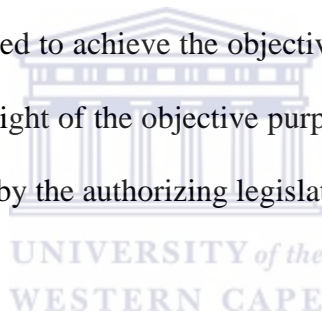
¹¹⁰ See Ross above note 6 at 488.

¹¹¹ In *Fitzpatrick* the Court found that the best interest principle in section 28(2) extends beyond the reach of the rights in section 28(1) to other provisions in the Bill of Rights. See *Minister of Welfare and Population Development v Fitzpatrick and Others* 2000 (3) SA 422 (CC) para 17.

¹¹² It is also entrenched in section 9 of the Children's Act.

¹¹³ See the case of *Sonderup* where the Court also found that the Act incorporating the Hague Convention on Civil Aspects of International Child Abduction Act 72 of 1996 was consistent with the Constitution because inter alia it served the best interest of children involved in custody matters. *Sonderup v Tondelli and Another* 2001 (1) SA 1171 (CC).

For the *third* factor, Woolman identifies five issues a court considers when evaluating the nature and extent of the limitation, these are (1) the Court looks at the ‘core’ values of the right and determines whether the limitation affects these ‘core’ values; (2) the Court considers the actual impact of the limitation on those affected by it (how severe is it?); (3) Sometimes the Court also considers the social position of the individual or group affected by the limitation (i.e do they occupy a vulnerable position in society in general); (4) The duration of the limitation is looked at by considering whether it is permanent or temporary. The Court also looks at whether the limitation is a partial or complete denial of the relevant right.; (5) Here the Court looks at how narrowly or broadly the limitation is tailored to achieve the objective. The question asked is what is the reach of the limitation in light of the objective purported to be served or what is the extent of the discretion given by the authorizing legislation.¹¹⁴



For the purpose of the hypothetical example under evaluation here only three of these factors need be considered, namely, the impact of the use of the status approach on the applicant’s health service right, the impact of the approach on the applicant herself and the reach of the limitation.

It has already been established that accessibility is central to health service rights. In other words, the ability to access health care services is a core value of the right to health care services. Section 129 does not allow children below 12 to access health care services on their own, they must be assisted by an adult in the form of a parent or

¹¹⁴ Woolman and Botha above note 36 at 34-79-84.

guardian. The section does not deny children below the age of consent of access to medical treatment or surgery, but makes the ability to access the services dependent on the presence and consent of an adult. K's case is that the health service rights as guaranteed in the Constitution are given to everyone and every child and is not dependent on a person's age, hence section 129 limits the core value of the right by setting age restrictions for accessing health care services.

On the second factor concerning the impact of the limitation it is contended that the status approach does not recognize the autonomy of a child below 12 because it assumes immaturity. In *S v M* it was held that '[i]ndividually and collectively all children have the right to express themselves as independent social beings...to themselves get to understand their bodies, minds and emotions, and above all to learn as they grow how they should conduct themselves and make choices in the wide social and moral world of adulthood',¹¹⁵ Respect for autonomy enhances the development of the child by allowing the child to make decisions on their own. The status approach takes away the need to take the views of the child below the age of consent into account because it assumes that the child will be unable to express those views because of their age.

This assumption thus results in mature minors not being able to participate in health care decisions or having their views regarding their health care adequately taken into account because they are assumed to be incapable of forming views. As soon as a health provider is satisfied that a minor is below the age of consent the minor's ability to express views

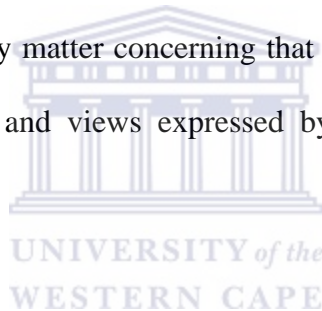
¹¹⁵ *S v M* above note 27 para 19.

regarding her health care is stayed until they come back with a parent. When a parent is present the views of that parent takes precedence and there is no need to consider the minor's views and even if the minor expresses such views they carry little or no weight because the minor is deemed immature by reason of age alone.

This right to participate in decisions involving the welfare of the child is also found in section 10 of the Children's Act which reads:

Child participation

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



The problem with the status approach in section 129 of the Children's Act is that it assumes that 12 is the ultimate age at which a child can rightly participate in health care decisions affecting that child despite the child's maturity and stage of development.

Although they need the guidance and assistance of parents when important decisions must be made, children's individuality and right to self determination must be respected. This right to self-determination is fundamental to the constitutional system.¹¹⁶ The notion of children's rights stem from the recognition that children are individual beings capable

¹¹⁶ P Carstens and D Pearmain (2007) *Foundational Principles of South African Medical Law* 99.

of being the bearers of their own rights and are no longer considered merely the subject of their parents' rights. This need to respect individuality was confirmed in the Christian Lawyers case where the court found that making maturity and not age the deciding factor when it comes to girls accessing termination of pregnancy services was a constitutionally valid approach taken by the legislature.

In further defending the use of the status approach the argument is advanced that section 129 serves the best interest of children. However, the best interest principle is also a flexible one which takes into account the individual circumstances of the child.¹¹⁷

Carstens and Pearmain note that

[i]t is the circumstances and capacity of the individual minor concerned, as opposed to minors as an amorphous group that must be considered by those rendering health care services. Broad generalisation when dealing with specific patients on the basis of factors such as age etc are not only inadvisable, they may also be unconstitutional in a number of different aspects not least of which is unfair discrimination'.¹¹⁸

The best interest of a child needing health care services such as medical treatment or operations must thus be individually assessed depending on the child's level of understanding and maturity and should not solely concentrate on the age of the child.

¹¹⁷ *Fitzpatrick* above note 111 at para 18.

¹¹⁸ Carstens and Pearmain above note 116 at 108.

Thus the impact that the status approach as found in section 129 of the Children's Act has on the applicant in the K matter is that it fails to respect her right to self determination by ignoring her individual capacity and circumstances because she is below the age of consent. This assumption of immaturity does not serve the best interest of the individual child and takes away or limits the mature minor's ability to participate in decisions regarding his or her health needs.

One other important factor to consider here is the duration and reach of the limitation. It appears that the disadvantages which the applicant in the K matter would suffer from the application of section 129 endures only until she reaches the 12 years of age because at that stage she will have the capacity to consent. This appears to be a short period considering that she is currently 10 years of age.¹¹⁹ However when looking at the impact of the status approach on children broadly and the fact that maturity is not static and depends on the individual child it is difficult to determine the exact duration which the limitation would take for those individual children. Thus to the extent that it was found that the sections unfairly discriminate against her it is clear that the discrimination is not of long duration.

The limitation does not appear to be absolute in that it does not deprive children below the age of consent of the ability to access health care services because they are young it only makes access dependent on whether or not the child is accompanied by an adult. However, it is this requirement of adult assistance that limits the right in the first place in

¹¹⁹ In *Khosa* Ngcobo J held that the limitation that the Social Assistance Act had on the right to social services for permanent residents was reasonable and justifiable because the limitation was neither absolute nor permanent. *Khosa* above note 33 at para 134.

that if the child is unaccompanied and below the age of consent the health care worker will not provide the necessary health care service unless the child comes with an adult (except where it is an emergency). In such a case where the child is turned away the right is denied in its absolute sense as a result of the provisions requiring adult assistance.

The *fourth* factor to consider is the relationship between the limitation and its purpose. In *Magajane* the Court held that ‘for law that limits a right to be reasonable and justifiable, there must be a causal connection between the purpose of the law and the limitations imposed by it’.¹²⁰ This factor thus requires a court to look at the relationship between the limitation and the means used to achieve its objectives¹²¹ or whether the means used to achieve the objective is reasonably capable of achieving that objective.¹²² The relationship between the limitation and its purpose is easily determined by looking at whether the limitation is overbroad or underinclusive. Rautenbach notes that ‘[a] limitation capable of furthering the purpose will be overbroad if it covers instances which has little or nothing to do with promoting the purpose...[and] the limitation will be underinclusive if it covers less than may be necessary to promote the purpose’.¹²³

Section 129 limits the health service rights of mature children to the extent that their access to health services is restricted and dependent on adult assistance. The purpose of

¹²⁰ *Magajane* above note 97 at para 72. In *Makwanyane* it was found that there was no rational connection between the death penalty and the state objective to reduce the incidence of violent crime. *Makwanyane* above note 88 at para 184.

¹²¹ *Iles* above note 42 at 83.

¹²² *Woolman and Botha* above note 36 at 34-84. For examples of cases where this factor failed the limitations analysis and it was found that the limitation was not rationally connected to the objective see *Woolman and Botha* at 34-79-85.

¹²³ *Rautenbach* above note 39 at 627.

the limitation is to protect children against their own immaturity by giving effect to their right to parental assistance in requiring parents to make health care decisions on behalf of younger children. The purpose of the limitation is also to serve the best interest of younger children. The legislature saw it fit to achieve these objectives by restricting children below the age of consent to only be able to access health services if accompanied by a parent or a guardian. Although the connection between the purpose of the limitation and the limitation cannot be denied the reach of the limitation may be too wide in respect of the purpose aimed at being achieved. The limitation is overbroad to the extent that it also catches the mature minor in its net even though the purpose of the limitation is to protect children against their own 'immaturity'.

The *fifth* factor set out in section 36 which a court can consider in a limitation analysis is whether there are less restrictive means to achieve the objective served by the limitation. If the court find that there is a legitimate purpose served by the limitation and that the limitation is rationally connected to its purpose then it will consider the issue of less restrictive means.¹²⁴ What the court looks at is again the reach of the limitation. As Rautenbach notes '[o]verbroad and underinclusive limitations imply that there are alternative ways to limit the right for a particular purpose'.¹²⁵

However this factor is not the decisive factor which determines the reasonableness and justifiability of the measures employed by the state to give effect to the right but must be

¹²⁴ Woolman and Botha above note 36 at 34-85. For cases where the state failed this requirement and the Court found that narrower means existed to achieve the objected see Woolman and Botha at 34-86.

¹²⁵ Rautenbach above note 39 at 627.

considered with all the other factors.¹²⁶ ‘Even where less restrictive means are available, the Court may still find that, on balance, the limitation is reasonable and justifiable’.¹²⁷ What is also important to note here is that when the effectiveness of alternative measures are looked at by the Court it should give the state a margin of discretion because ‘the role of the Court is not to second-guess the wisdom of policy choices made by the legislators’.¹²⁸

The legislature wants to protect minors against their immaturity by assuming via section 129 that children below 12 years of age are immature. It is contended that this objective can also be achieved by operation of the maturity test which is also part of section 129. If maturity to make decisions is the concern for the legislature then surely this concerns can simply be addressed by requiring the health care provider to test the maturity of the child. In other words ‘if an age restriction is placed on applicants, because of ordinary attributes usually given to people who fall within that age group, then age alone should not be the overriding consideration where applicants who fall outside the age group nevertheless meet the criteria consistent with the purpose behind that restriction’¹²⁹ This approach has been shown to work in the case of a termination of pregnancy where maturity rather than age determines a girl’s ability to have an abortion. The same approach is also taken in the Children’s Act in so far as children younger than 12 can consent to an HIV test if they are

¹²⁶ *S v Mamabolo (Etv and Others intervening)* 2001 (3) SA 409 at para 49.

¹²⁷ Woolman and Botha above note 36 at 34-91. Iles notes that ‘Whether or not the fact that a less restrictive means was available and was not used should disqualify a limitation will then depend upon the importance of the purpose of that limitation, the extent to which it infringes the right and the nature of the right being infringed’. See Iles above note 42 at 85.

¹²⁸ Currie and de Waal above note 58 at 184. Rautenbach above note 39 at 631-634.

¹²⁹ K Hopkins (2006) *De Rebus* 24 at 27.

mature enough to do so.¹³⁰ So when it comes to medical treatment and surgery the immature minor will still be protected from making harmful decisions where he or she is found by the health care worker not to be mature enough to give informed consent to such treatment or surgery. Focusing on maturity rather than age will then make less inroads on young children's ability to access health care services on their own and will respect their autonomy and give effect to the best interest of the individual child. There are therefore indeed less restrictive means to achieve the objectives of the legislature.¹³¹

4.4 EVALUATION AND CONCLUSION

Having considered the factors in section 36 and how they would apply to the hypothetical example of the K matter, what a court would then have to do is to balance the competing interests involved in the matter by considering the nature and importance of the infringed right, on the one hand, and the purpose, importance and effect of the infringing provision, taking into account the availability of less restrictive means available to achieve that purpose'.¹³² In *Jaftha* the Court found the nature of the right and the nature and extent of the limitation are of great importance when weighed against the importance of the purpose of the limitation.¹³³

¹³⁰ Section 130 of the Act.

¹³¹ In *S v Williams* above note 103 the Court found at para 91-92 that there was enough sentencing options in the South African justice system to conclude that juvenile whipping did not have to be resorted to.

¹³² *S v Manamela and Another (Director-General of Justice Intervening)* 2000 (3) SA 1 (CC) at para 66.

¹³³ *Jaftha* above note 35 at para 36.

Although the importance of the purpose of setting age limitations for children accessing health care services is very important it must be weighed against the impact that it has on the health service rights of mature minors below the age of consent and on those minors themselves. The right to basic health care services and the right to access health care services in the Constitution are given to everyone and to every child and those rights cannot be overridden 'simply on the basis that the general welfare will be served by the restriction'.¹³⁴ All the relevant factors must thus be weighed against each other to establish whether the use of the status approach is a reasonable and justifiable limitation of the health service rights of mature children below the age of consent.

In considering the arguments advanced as far as the nature and extent of the limitation is concerned, the following conclusion is made. Firstly, the limitation of the rights is of limited duration (it only lasts up until the age of 12), but the infringement of the right does not cease because it is of limited duration.¹³⁵ Although the discrimination which results from section 129 is of limited duration and 'everyone is at a point in their life subject to ...age restrictions....'¹³⁶ the problem is that 'there will always be a category of children, this category will always be treated differently and their rights [will] always be restricted.'¹³⁷ Secondly, there appears to be no absolute denial of access to health care services, but where situations arise in which health care providers refuse to assist children below the age of consent when they are unaccompanied by a parent or guardian then there is a complete denial of the right.

¹³⁴ Currie and de Waal above note 58 at 164.

¹³⁵ *Mohamed NO and Others v National Director of Public Prosecutions and Another* 2002 (4) SA 366 (W) at para 21.

¹³⁶ Currie and de Waal above note 58 at 256.

¹³⁷ Breen above note 5 at 25.

The limitation on the children's rights is also not justified when one considers the relationship between the purpose of the limitation and its objective as well as the fact that there are less restrictive means available to the legislature which could serve the same purpose. Section 129 only marginally contributes to achieving its purpose because even though its ultimate aim is generally to protect immature minors from making harmful health care decisions the protection net is thrown so wide that it also captures mature minors below the age of consent. This is not necessary for purposes of the protection objective which the limitation serves. Thus the purpose that the section serves is not adequate to justify the infringement.¹³⁸

The objective of the legislature can also easily be achieved by requiring the maturity test to determine the minor's ability of accessing health care services which would result in less inroads to their health service rights.¹³⁹ Such an approach would prevent 'frustration of a constitutional right when the minor is in fact emotionally and intellectually able to give informed consent to the procedure.'¹⁴⁰ Thus, seeing that this approach has proved successful when it comes to a termination of pregnancy the limitation (and that the same approach is indirectly used in the Children's Act when it comes to children consenting to an HIV test)-to borrow words from Carstens and Pearmain- '[i]n principle it is difficult to

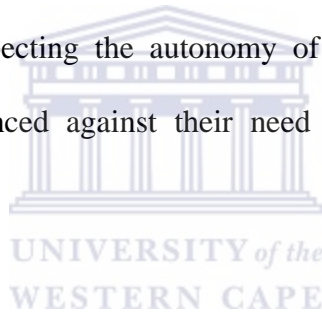
¹³⁸ Currie and de Waal above note 57 at 183.

¹³⁹ The more substantial the inroad into fundamental rights, the more persuasive the ground of justification must be. *S v Bhulwana* above note 92 at para 18.

¹⁴⁰ *Christian Lawyers* above note 22 at 517

see why the logic of Majapelo J in [*Christian lawyers*]... cannot be applied to most if not all health care services for minors'.¹⁴¹

Having regard to the above there is a definite case to be made that the limitations placed on children's health rights are not justifiable in an open and democratic society when the status approach is used. In *S v M* the Court noted that the 'four great principles of the CRC which have become international currency, and as such guide all policy in South Africa in relation to children, are said to be survival, development, protection and participation'.¹⁴² Although the objectives of section 129 accords with the CRC's principles of development, and protection of the child, such development and protection can also be advanced by respecting the autonomy of the child. Children's need for protection must thus be balanced against their need to be regarded and treated as individuals.¹⁴³



As long as these presumptions of incompetence exist without considering the individual development of the child then mature children's right of access to health care services will always be frustrated in one way or another. So, to use the suggestion of Muthcherson '[a]ny change in the law's treatment of young people in the healthcare context must start from the premise that children are not monolithic, meaning that all of

¹⁴¹ Carstens and Pearmain above note 116 at 108.

¹⁴² *S v M* above note 27 at para 17.

¹⁴³ B Clark (2001) *THRHR* 605 at 617.

those who are legally minors [and]... below the age of [12] should not be labelled immature, incapable, and decisionally dependent.’¹⁴⁴



¹⁴⁴ K Muthcherson (2005) *Cornell Journal of Law and Public Policy* 251 at 258. Retrieved 12 November 2007, from Westlaw online database.

CHAPTER 5: CONCLUSIONS

This thesis concerned itself with health service rights and the children as right holder. Chapter 2 aimed to set out the entitlements and obligations created by health rights in section 27 and section 28(1)(c) the Constitution. The chapter highlighted the Constitutional Court's jurisprudence on socio-economic rights in general and explored the interpretation of children's health rights within the context of this particular jurisprudence.

Chapter 3 and 4 probed further the guarantees of health service rights but aimed to illustrate that a right to access health care services entitles the right holder to more than mere geographic or financial access. 'Access' to health care services means having the ability to obtain such services and the ability to do so is not dependent only on financial or geographical factors. Chapter 3 and 4 served to illustrate how the issue of consent can also be a determining factor when it comes to the ability to access health care services. In chapter 3 the consent provisions of the new Children's Act was considered and the relationship between these provisions and children's health service rights highlighted. The chapter indicated that although the consent provisions in the Act go a long way in giving effect to the guarantees created by health service rights more, will still need to be done before children could experience the optimal enjoyment of their health service rights.

Chapter 4 explored the issue of consent further and examined particularly the use of ages of consent in health provisions like the ones in the current Children's Act. Ages of consent are commonly used as criteria to determine children's ability to consent to medical treatment or surgery without parental or guardian assistance. This is the status

approach. In chapter 4 a hypothetical example was used to carry out a constitutional evaluation of the use of this approach against the general limitations clause. This was done so as to bring illustrate the effect that the status approach has on the ability of mature minors below the age of consent to access health care services. The conclusion reached in chapter 4 was that the use of the status approach limits the health service rights of children below the age of consent and that this limitation could not be justified in terms of the limitations clause. Although a court may come to a different conclusion to the one advanced in chapter 4 the crux of the chapter was to illustrate that there are arguments to be made against consent laws which prevent minors from adequately enjoying their health service rights and that the problem with these laws is that it fails to give adequate attention to the guarantees given to those children as owners of health service rights.



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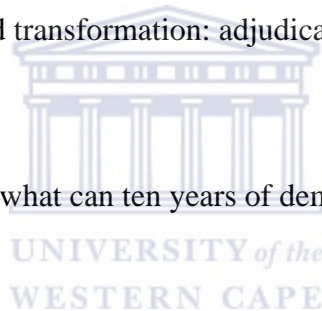
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