

Key legislative developments in 2009/2010: Child health rights

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Article 24 of the United Nations Convention on the Rights of the Child provides for “the right of the child to the enjoyment of the highest attainable standard of health”. This provision expands on the right to health in the International Covenant on Economic, Social and Cultural Rights, and a similar right is found in article 14 of the African Charter on the Rights and Welfare of the Child.

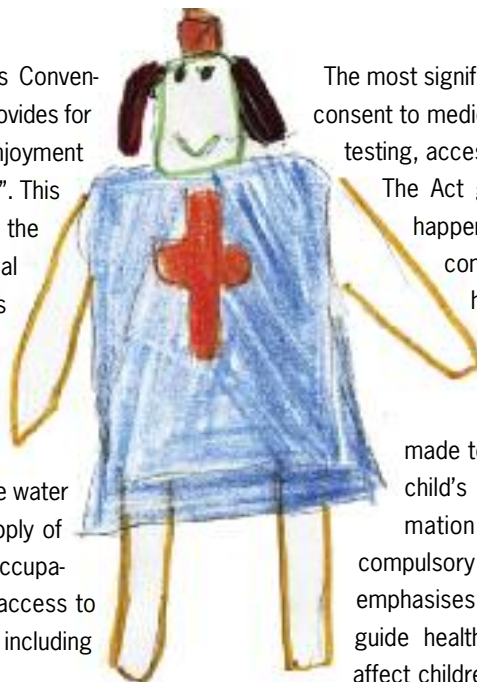
The treaties define health broadly to include the underlying determinants of health such as “access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health related education and information, including on sexual and reproductive health”.¹

The South African Constitution includes children's right to basic health care services and a range of socio-economic rights that place the same obligations on the State as the right to health in international law (see pp. 22 – 28).

The essay in this section describes and interprets legislative developments relevant to child health in 2009/2010. These include the Children's Act, the Prevention of and Treatment for Substance Abuse Act, provincial health legislation, the Tobacco Products Control Amendment Acts, the regulations to the Basic Conditions of Employment and new regulations to the Social Assistance Act.

Children's Act

The Children's Act (as amended by the Children's Amendment Act)² came into full force on 1 April 2010. The accompanying regulations also came into operation on the same day.³ The Act repeals the Child Care Act⁴ and contains a number of new provisions relating to child health.



The most significant changes for child health focus on consent to medical treatment, surgical operations, HIV testing, access to contraceptives and circumcision.

The Act gives clear direction on what should happen when a child lacks the capacity to consent, and on children's right to refuse health services. It also introduces children's rights to participate in health decisions and to access a range of health information. Provision was made to ensure confidentiality in relation to a child's health status and treatment information. The Act also provides for the compulsory reporting of abuse and neglect. It emphasises that the child's best interests must guide health professionals in all decisions that affect children.

Consent

The new law allows for caregivers such as grandmothers to consent to medical treatment and HIV testing for children in their care. Previously, the law specified an age threshold of 14 years for treatment and 18 years for surgery. Now health professionals must consider both the *age* and the *maturity* of the child. The Act allows children 12 years and older to consent to medical treatment or a surgical operation if they are “mature” enough to understand the benefits, risks, social and other implications of the treatment or operation.

The parent or guardian must assist a child over 12 when making a decision about a surgical operation. When a child is too young or lacks capacity, a parent or guardian can give consent, but must consider any views expressed by the child. However, the age threshold of 12 years and older does not apply to a girl child seeking a termination of pregnancy either through medical treatment or surgery because the law that regulates abortions is not the Children's Act, but the Choice on

Termination of Pregnancy Act,⁵ which allows a girl of any age to consent to an abortion, provided she can give informed consent.

A child over 12 years can consent to an HIV test and the disclosure of his/her HIV/AIDS status. A child younger than 12 can also consent to testing or to the disclosure of his/her HIV status, if mature enough to understand the risks, benefits and social implications of the test or the disclosure. No child may be tested without receiving counselling before and after the test. An HIV test must be in the child's best interests and the relevant consent must be obtained.

A court can order that a child is tested for HIV when it is necessary to establish if someone has contracted the virus from contact with the child's bodily fluids. For example, if a child is alleged to have committed a sexual offence, a magistrate can order an HIV test in terms of the Sexual Offences Act⁶ to find out if the victim was exposed to HIV during the alleged offence.

To access contraceptives, a child should be 12 years or older, and no maturity test is required. The Act says that no one (including a health professional) may refuse condoms to a child older than 12 years. This strong wording aims to ensure that teenagers have unrestricted access to condoms to protect themselves against sexually transmitted infections (STIs), HIV, and early pregnancy. To access contraceptives other than condoms, the child must undergo a medical examination, and must be given proper medical advice on how and when to use the contraceptives, and possible side-effects. The Act expressly obliges health professionals to respect children's confidentiality when requesting contraceptives – again to provide a supportive environment for teenagers to access essential reproductive health services.

Female circumcision or genital mutilation is banned by the Children's Act. However, circumcision can be performed on boys for cultural, religious or medical purposes. When it comes to cultural circumcision, a boy has to be 16 years or older and he must consent to the circumcision. Every male child has the right to refuse circumcision if he is mature enough to understand the consequences. Religious circumcision can be performed on a boy younger than 16 if the parents or guardians consent. Boys older than 16 can consent to religious circumcision, but must be assisted by a parent or guardian.

Medical circumcision is treated as a surgical operation and can be performed only for medical reasons on the recommendation of a medical practitioner. Only a medical practitioner or person with knowledge of the cultural or religious practices of the child and who has been properly trained to perform circumcisions can do so. The Children's Act regulations outline the circumcision procedure to safeguard the health of the child.

When a child lacks capacity to consent

When a child does not have the legal capacity to consent, a parent or guardian can consent to any procedure, including surgery. Caregivers (people like grannies or foster parents) may consent only to medical treatment and HIV testing. Designated child protection organisations (eg Child Welfare South Africa) can consent to an HIV test or the disclosure of a child's HIV status when arranging the placement of a child (either in foster care or adoption).

If the child does not have capacity to consent and the parents are unavailable or unreasonably withholding consent, the provincial head of social development, the courts or the Minister of Social Development can consent. A hospital superintendent or the person in charge of a hospital can consent to emergency surgery or urgent treatment to save the life of the child or prevent permanent disability if there is no time for the usual consent procedures.

A right to refuse health care

The Constitution protects children's right to bodily integrity and the National Health Act⁷ obliges health practitioners to inform health users (including child patients with the capacity to consent) about their right to refuse treatment. The Children's Act does not explicitly grant children the right to refuse treatment or surgery; however, it does acknowledge such a right by noting that the Minister of Health can consent to a child's medical treatment or surgery if the child "unreasonably" refuses consent. This implies that refusal will be respected if reasonable. However, as with the right to consent, only a child of consent age and who is mature enough to understand the risks and consequences of refusing can exercise the right to refuse health care.

Health information

Children have a right to information about their health and to participate in the decision-making process even if they do not have the right to consent. All children have a right to information about their own health and treatment options, and to general health information on health promotion and prevention, and on sexual and reproductive health in particular. Adopted children and children conceived artificially have a right to access medical information about their biological parents. The Children's Act requires that information must be provided in a format accessible to children, including children with disabilities.

Reporting and confidentiality

The Act upholds the child's right to privacy and physical integrity by requiring that the child's health status and the status of his/her parents or family members be kept confidential. Any unautho-

rised breach of confidentiality about HIV/AIDS status is an offence. The Act provides that confidentiality may be breached if it is in the best interests of the child. Health professionals will have to make a judgement call in each instance, based on the factors for determining best interests listed in the Act – for example, the nature of the child and parent’s relationship must be considered when deciding to inform a parent of the child’s HIV status.

The Act instructs health professionals to breach confidentiality if they conclude that the child has been abused or deliberately neglected. Health professionals are amongst a range of professionals obliged to report an incident of abuse or deliberate neglect to a police officer, the Department of Social Development, or a social worker. A young child presenting with an STI, a 13-year-old requesting condoms who reveals that she is having sex with an adult, or a child with signs of physical assault are examples of where confidentiality must be breached to ensure the child is protected from further abuse.

Strengths and weaknesses

The law now requires health professionals to assess the child’s maturity. However, neither the Act nor its regulations provide guidance on how maturity should be assessed. This could result in children being treated differently or health professionals simply using the age threshold as the determining factor. The regulations state that the consent form has to be completed by the person performing surgery on a child, or a representative of the facility where the operation will be done. When completing the form, this person is required to indicate that s/he has explained to the child the nature, consequences, risks and benefits of the surgery, and that s/he is satisfied that the child is of sufficient maturity and has the mental capacity to understand the risks, benefits, social and other implications of the operation.

Currently, it is common practice for receptionists and administrators to complete the consent forms, and the Act would appear to allow this because they could be considered a “representative of the facility”. However, assessing the child’s maturity and mental capacity to understand the risks, benefits, social and other implications of the operation is a skilled task that should be done only by trained professionals.

The provisions are not so clear about who should determine maturity for medical treatment or HIV testing. However, the precedent set in the regulations for surgery can be applied to medical treatment, meaning that the health professional treating the child must assess maturity. This could be a doctor, nurse or lay counsellor, depending on the facility and

type of treatment. The additional responsibility placed on health professionals to determine the maturity of children will contribute to their already heavy workload. They will need training and additional capacity to meet this new requirement.

Allowing younger children, caregivers and others to consent to medical treatment and HIV testing will ensure that more children can receive treatment, and that children’s health needs are not delayed while tracing parents or guardians for consent. The new consent provisions also respond directly to evidence of earlier sexual debut in teenagers. The Department of Health has acknowledged research indicating that some children are engaging in sex well before the age of 14.⁸ Removing barriers to children’s access to contraceptives and medical treatment for STIs will reduce the incidence of teenage pregnancies, HIV and other sexually transmitted diseases.

The Child Care Act did not prescribe specific forms to be completed when reporting child abuse or neglect, but the Children’s Act regulations include a standardised form that must be completed by health professionals (and others). The introduction of this form sets a higher standard of record-keeping and includes a detailed description of the full circumstances of the child to ensure adequate protection.

Prevention of and Treatment for Substance Abuse Act

The Prevention of and Treatment for Substance Abuse Act⁹ was signed by the President and published in the *Government Gazette* on 21 April 2009, but is not yet in operation. It provides for a co-ordinated strategy and services to reduce the supply of and demand for substances which can be abused, such as drugs and alcohol.

The Act provides for prevention and early intervention services that are specifically aimed at children and families. It complements the Children’s Act by identifying a range of supportive measures such as parenting, peer education, sports and leisure, and educational programmes to increase children’s and youth’s “capacity to make informed healthy choices”. It refers to the Children’s Act in relation to the reporting of children who abuse substances, and the placement and treatment of such children, and provides that children and adults must be treated separately.

A major weakness in this Act is that it does not explicitly provide for all children to participate in decisions on their admission to a treatment centre. Voluntary admissions can be processed in two ways: Either the child can submit him/herself for treatment, or a parent can apply for the child to be admitted.

In accordance with the Children's Act, *only* children 12 years or older and mature enough to consent to treatment should be able to admit themselves voluntarily.

However, the Prevention of and Treatment for Substance Abuse Act also allows parents to apply for admission of a child of any age. The Act provides no guidance on what should happen if there is a conflict between a parent and a child who is at least 12 and mature enough to understand the risks and benefits of the treatment. Yet such a child has the right to refuse treatment. If the child unreasonably refuses treatment that is deemed in his/her best interests, the provisions of the Children's Act can be invoked, and the parents can apply to the Children's Court for an involuntary admission.

Another weakness of the Prevention of and Treatment for Substance Abuse Act is the procedure for the involuntary admission of a child, which states that section 152 of the Children's Act should be used to admit a child to a treatment or child and youth care centre. Yet, section 152 was designed to provide for the removal of a child to temporary safe care without a court order in emergencies. It is a measure of last resort and should be invoked only when it is absolutely necessary to protect the child from immediate danger and if "delay in obtaining a court order for the removal of the child and placing the child in temporary safe care may jeopardize the child's safety and well-being". If there is no immediate danger, the child has a right to have the matter considered by a court.

The General Principles of the Children's Act guide the implementation of all legislation applicable to children, including the Prevention of and Treatment for Substance Abuse Act. The General Principles provide that all proceedings, actions or decisions concerning a child must respect, protect, promote and fulfil the child's constitutional rights, including the rights to physical integrity and dignity. The child must be treated fairly and equitably and must be informed of any action or decision taken in any matter concerning him/her. Depending on the child's age, maturity and stage of development, s/he has the right to participate in the decision-making process.

The Department of Social Development needs to issue a directive to clarify how these two Acts should be interpreted and implemented when the child falls under the ambit of both laws.

Tobacco Products Control Amendment Acts

Parliament amended the Tobacco Products Control Act¹⁰ in 2007 and 2008; both the Amendment Acts¹¹ came into force on 21 August 2009. They introduce child-specific amendments to the principal Act.

Whereas the original Act prohibited the sale or supply of tobacco products to children under 16, the amendment raises this age threshold to 18. The owner or person in charge of a business must now also ensure that employees under the age of 18 do not sell or supply anyone with tobacco products. The Act also outlaws the supply and sale of tobacco products in places where persons under 18 receive education or training. The restrictions even apply to the use of cigarette vending machines – these must be located out of the reach of children.

Anyone who fails to comply with these provisions will be guilty of an offence and could be fined up to R100,000. Smoking a tobacco product in a "motor vehicle when a child under the age of 12 years is present in that vehicle" is now prohibited and punishable by a fine of up to R500.

These amendments protect the general health and well-being of the child by covering different settings in which a child's health could be compromised.

Provincial health legislation

The Constitution provides that the national and provincial governments share responsibility for health care. This means provincial parliaments can pass laws to regulate the health system in their province, as long as these laws are not in conflict with the National Health Act. In 2009, both KwaZulu-Natal¹² and the Free State¹³ provinces passed health Acts. The Free State Act has commenced; the KwaZulu-Natal Act is not yet in force. Both Acts aim to bring provincial health laws in line with the National Health Act and the Constitution. The Western Cape¹⁴ and the North West¹⁵ provinces have recently prepared legislation that is still to be considered by their parliaments.

In keeping with the National Health Act, the KwaZulu-Natal and Free State Acts oblige health users to treat health care *providers* with dignity and respect. However, none of these Acts emphasise the right of health *users* to be treated with dignity and respect.

The National Health Act establishes a district health system and requires provinces to pass legislation to set up district health councils and committees for clinics and community health centres. The councils and committees are mechanisms for public participation in health decision-making. Guidance from the United Nations Committee on the Rights of the Child makes it clear that children's right to participate includes decisions about policy and service delivery.¹⁶ Therefore, these health councils and committees should facilitate the active partici-

pation of children. Both the Free State and KwaZulu-Natal Acts provide for these committees and councils but are silent on the issue of children's participation.

Basic Conditions of Employment Act regulations

The general rule in terms of the Basic Conditions of Employment Act¹⁷ is that children can only be employed from the age of 15 (certain exceptions apply to children below this age who are allowed to perform labour for advertisements, sport or in artistic or cultural events). New regulations on Hazardous Work by Children¹⁸ came into effect on 7 February 2010 to prevent exploitation and abuse of children at work, and to ensure that they work in a safe environment and are not exposed to risks. A 'child worker' is defined as a person under 18 years who works for an employer and who receives or is entitled to receive remuneration.

The regulations detail the risk factors that an employer must consider when a child is employed. These include children's biological sensitivity to chemicals, increased vulnerability to sleep disruption, reduced ability to perceive danger correctly, and relative lack of experience and maturity in making safety judgements. Employers may not allow children to do work that requires them to wear respiratory protection. Employers of child workers must display a summary of these regulations in the workplace to ensure that children and their co-workers are fully aware of the protection that they are entitled to.

The regulations set out guidelines and conditions for employers of child workers who work in elevated positions; lift heavy weights; work in a cold, hot or noisy environment; or use power tools, grinding and cutting equipment. These regulations assume that employers will have the skills and equipment necessary to keep noise and temperatures within the recommended limits.

Where the regulations have been contravened, labour inspectors are required to refer cases to a child protection organisation in terms of the Children's Act. A person found guilty of breaking the regulations shall be liable to a fine or 12 months imprisonment. However, it will be difficult to detect such violations of children's rights as most contraventions are only picked up through complaints or routine inspections. Only a small proportion of labour inspectors' time is dedicated to child labour – and most children are employed where law enforcement is virtually absent: in the informal sector, on farms, as seasonal workers in the hospitality industry, or in domestic service.

Social Assistance Act regulations

In December 2009 the Minister of Social Development published an amendment¹⁹ to the regulations of the Social Assistance Act²⁰. The regulations relate to eligibility for the Child Support Grant (CSG) and came into force on 1 January 2010. A second amendment²¹ was published on 12 March 2010 but was back-dated to apply from 1 January 2010.

Age threshold

The Department of Social Development has removed the age restriction on the grant after a decade of advocacy by civil society, which included legal challenges to the constitutionality of the regulations.²² The second amendment to the regulations states that caregivers of children born on or after 31 December 1993 are eligible for the CSG with effect from 1 January 2010, and shall continue to receive the grant until the child turns 18. This means that up to 2 million more vulnerable teenagers will benefit from the grant. There is evidence that the extra income will enable families to provide nutrition and pay for transport for children to access a range of government services including education, health, social services and home affairs.²³

Additional requirements – school attendance

The new regulations require caregivers to provide proof of school enrolment and attendance for children between seven and 18 years to the South African Social Security Agency within one month of approval of a new CSG application. Caregivers must send the child's school report, signed by the principal, to the national Director-General of Social Development every six months. If the child is not enrolled or fails to attend school, the caregiver must give reasons in writing. The regulations require the Department of Education to notify the Department of Social Development of any child who is not enrolled or fails to attend school.

The additional requirements are not conditions that caregivers need to meet when applying for the CSG, and the grant cannot not be withdrawn if a caregiver fails to provide proof of enrolment and attendance. Instead, a social worker will be sent to investigate and support the family to keep the child in school.

However, there are questions on how these regulations will be implemented. For example, it is not clear how school principals will know if children are not enrolled, as the children may have moved to another school. Similarly, where will the Department of Social Development find social workers to assign to these cases, given current shortages? Thankfully these additional requirements are not punitive to the caregiver.

Whatever problems the two departments have in implementing these regulations, they shall not affect caregivers' eligibility for the CSG.

Conclusion

To obtain the highest standard of health, children need access to health care services, healthy environments and access to basic necessities such as food, water and social assistance. The Children's Act provides that children have greater access to information that will help them to lead healthy lives, including information about sexual and reproductive health. The Act also ensures greater access to health care services by allowing more people to consent to the treatment of children. The extension of the CSG will enable poor families to provide basic necessities, and keep teenagers in school.

If effectively enforced, the regulations on Hazardous Work by Children should lead to healthier working conditions. The amendments to the Tobacco Products Control Act should protect children from the health risks associated with smoking.

All the above laws require large-scale budgets and investment in human resources. Parliament now has the power to amend national budgets and, with input from civil society, determine priority spending areas. However, budgets alone are not sufficient to implement laws. There is a critical shortage of skilled workers to provide the services required by the new legislation. The services discussed require additional health practitioners, social workers, labour inspectors, police officers and other professionals. The government needs to invest in the training and development of these practitioners if these services are to be delivered to all the children who need them.



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