



THE CHILDREN'S ACT NO 38 OF 2005¹

A guide for health care practitioners

Second edition 30 July 2008

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INTRODUCTION

The main objective of the Children's Act is to give effect to children's constitutional² rights to:

- family care, or parental care or appropriate alternative care when removed from the family environment;
- social services;
- be protected from maltreatment, neglect, abuse or degradation; and
- to have their best interests be of paramount importance in every matter concerning the child.

The Act gives effect to these rights mainly through the provision of a range of social services for children and families. These include crèches and early childhood development programmes, prevention and early intervention programmes, protection services, foster care and cluster foster care, adoption, and child and youth care centres. The Act also regulates surrogate motherhood and trafficking.

For health care practitioners there are certain provisions in the Act that are of particular importance. These include the sections that set out new principles relating to children, their parents and the health practitioner's role in decision-making with regards to health care services.

¹ As Amended by the Children's Amendment Act 41 of 2007

² Republic of South Africa. The Constitution of the Republic of South Africa (Act 108 of 1996);

STATUS OF THE ACT

The Children's Bill was first tabled in Parliament in 2003. It covered a range of different services some of which are the responsibility of national government (e.g. children's rights, adoptions, parenting rights, and courts), and some of which are the shared responsibility of both national and provincial governments (e.g. child and youth care centres, early childhood development programmes and protection services). The rules of Parliament set out different procedures for laws governing national responsibilities versus laws where responsibility is shared between national and provincial government. Therefore the Children's Bill had to be split into two bills. The first one dealt with matters which national government is responsible for.

Parliament passed the first Children's Bill on 14 December 2005. The President signed it into law in June 2006 and its official name and number is the Children's Act No 38 of 2005. On 29 June 2007, the President published a proclamation in the Government Gazette for the commencement of certain sections of the Children's Act on 1 July 2007. This includes the majority of the sections regulating who can consent for health care services for children.

The second Children's Bill was passed by Parliament on 22 November 2007 and signed into law by the President in March 2008. It is called the Children's Amendment Act No 41 of 2007.

The full Act will not come into force until the regulations have been finalised (this is anticipated to happen only in 2009). The Child Care Act of 1983 therefore still governs the main areas of the child care and protection system until the new Children's Act is put into full force.

LEGISLATION TO BE REPEALED

The Children's Act is a comprehensive piece of legislation on matters affecting children. It will eventually repeal other legislation including the Children's Act of 1960, Age of Majority Act of 1972, Child Care Act of 1983, Children's Status Act of 1987, Guardianship Act of 1993, and the Natural Fathers of Children born out of Wedlock Act of 1997.

PROVISIONS IN THE ACT

GUIDING PRINCIPLES AND CHILDREN'S RIGHTS

Best interests of the child (effective as of 1 July 2007)

The Act reinforces the constitutional principle that the best interests of a child are of paramount importance in every matter concerning the child. It lists the factors to be taken into consideration when deciding on the "best interests of the child" (See sections 2(b), 7 and 9).

Child participation (effective as of 1 July 2007)

A new principle in the Act is "Child participation" (Section 10). This states that "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." (Emphasis added)

Therefore, even if a child needs his or her parent to consent on his/her behalf, the child still has the right to be involved in decision-making related to his or her health, especially if it is likely to

significantly change, or to have an adverse effect on, the child's health. This means that the child should be given the necessary information in a child friendly way to enable the child to express his or her opinion.

Access to information on health status and treatment (effective as of 1 July 2007)

Patient's, including children, have a right to have sufficient information about their health to enable them to make an informed decision about treatment or the refusal thereof. Section 13 of the Act provides that every child has the right to –

- (a) have access to information on health promotion and prevention and treatment for ill-health and disease, sexuality and reproduction;
- (b) have access to information regarding his or her health status;
- (c) have access to information regarding the causes and treatment of his or her health status;

In addition, the information must be relevant and must be in a format accessible to children, giving due consideration to the needs of disabled children. Thus, the current Informed Consent document(s) for treatment and operations which are geared in favour of adults must be made more user-friendly for children.

Right to confidentiality (effective as of 1 July 2007)

Section 13 provides that information on a child's health status or the health status of the child's parent, care-giver or family member must be kept confidential except when maintaining such confidentiality is not in the best interests of the child.

Children with disability or chronic illness (effective as of 1 July 2007)

An obligation is placed on persons, including health practitioners, to give due consideration to providing special care (as and when appropriate) when dealing with children with a disability or chronic illness. The aim of Section 11 is also to ensure dignity of, promote self-reliance of, and provide necessary support services to such children. An example of this would be, where a health practitioner should consider employing a sign reader if s(he) deals with many deaf children and providing an informed consent document in Braille if treating blind children, etc.

Age of majority (effective as of 1 July 2007)

Section 17 of the Act states that the age of majority is now 18 years, and not 21 years as was the case previously. The age of majority is the age at which a person is considered responsible and liable for actions or inactions under the law, for example at 18 a person can give their own consent to be part of a clinical trial or sign a legally binding contract concerning payment for their health treatment. Person's under the age of 18 will need their parents consent to bind themselves legally.

PROVISIONS RELATING TO HEALTH CARE DECISIONS

Section 129: Consent to medical treatment and surgical operations (not yet in effect because regulations still need to be drafted)

Consent by a child

Consent to Medical Treatment

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 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.

Consent to Surgical Operations A child may consent to the performance of a **surgical operation on him or her, or on his or her child** if-

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

Regulations are still being drafted on this section of the Act. What is important to note is that children as young as 12 years may now consent to medical treatment for themselves or their own child(ren). However, for operations on the child or her child(ren), assistance is required from the parent or guardian. The determining factor is not so much the age of the child, but rather the maturity and capacity of the child to understand the benefits, risks, social and other implications of the treatment or surgical operation.

Different types of treatment require different levels of understanding and responsibility. A child may be mature enough to understand the risk and benefits of receiving minor surgery for a physical injury, but not mature enough to understand the risk and benefits of undertaking long-term treatment for a chronic illness. The maturity requirement in the Children's Act will give the flexibility to require adult guidance where the health practitioner deems it necessary.

As in previous legislation, there is no definition for "treatment" and "operation". Treatment would refer to non-invasive and innocuous procedures, and include vaccinations. However, an operation generally refers to surgical intervention.

Consent by parents, and guardians

Consent to medical treatment:

For children under 12, or children over 12 but without sufficient maturity to understand the risks and benefits, the parents or guardian need to consent on the child's behalf.

Consent to surgical operations:

For children under 12, or children over 12 but without sufficient maturity to understand the risks and benefits, the parents or guardian need to consent on the child's behalf.

For children over 12 who have sufficient maturity, the parents need to assist the child to reach a decision. The child has the power to give or withhold consent, so if there is a dispute between the child and the parent, it is the child's view that must be respected.

Who is a parent?

Both parents have full parental rights and either parent may consent individually to medical treatment or surgery. However, where a decision could "significantly change, or have an adverse effect on the child's...health" the person giving consent must take into consideration "any views and wishes expressed by any co-holder of parental responsibilities and rights", e.g. the other parent. (section 31).

Biological mothers:

The biological mother of a child, whether married or unmarried, has full parental responsibilities and rights.

However, if the biological mother is under 18 years, the guardian of the biological mother, is also the guardian of the child (Section 19). Notwithstanding this section, a child may consent independently to the medical treatment of her child. However, in cases of an operation on such child, the under 18 year old mother must be assisted by her own parent or guardian.

Biological fathers:

The biological father of a child has full parental responsibilities and rights in respect of the child if he is married to the mother of the child or was married to the child's mother at the time of the child's conception, birth or anytime between conception and birth.

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

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

- (a) If he is living with the child's mother at the time of the child's birth in a permanent life-partnership then he has full parental rights and responsibilities
- (b) Regardless of whether he has or has not lived with the mother, he can acquire rights if the following three conditions are present:
 - he consents to be identified as the father or applies to the court to be recognised as the child's father or pays damages in terms of customary law;
 - he contributes or has attempted to contribute in good faith to the child's upbringing for a reasonable period; and
 - he contributes or has attempted to contribute in good faith to the expenses in connection with the maintenance of the child for a reasonable period.

If there is a dispute as to whether any of these conditions exist then the matter must be referred for mediation to a family advocate, social worker, or social service professional.

What happens in cases when parents are divorced?

It depends on the Divorce Order, in particular the provisions with respect to guardianship, care (new term for custody) and contact (new term for access). Notwithstanding such an Order, in cases of uncertainty, the "best interests of a child" must always prevail.

What happens when a parent withholds consent unreasonably?

No parent guardian or care-giver of a child may refuse to assist a child or withhold consent 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 -Section 129(10).

Consent by care-givers with no formal parental responsibilities and rights (e.g. grannies)
(not yet in effect)

Section 32 provides for a person with no formal parental responsibilities and rights to consent to any medical examination or treatment of the child if such consent cannot reasonably be obtained from the parent or guardian of the child. Such a person would include anyone who voluntarily cares for the child either indefinitely, temporarily or partially, including a care-giver. This clause is aimed at assisting the many children being cared for by relatives to access health care services more easily.

Who is a care-giver ?

A care-giver is anyone who factually cares for a child, and includes:

- grannies, aunts and other relatives;
- a foster parent;
- the head of a child and youth care centre;
- a child and youth care worker supporting children in the community without care in the family; and
- the child heading a child headed household.

Consent by Superintendent

The superintendent of a hospital or the person in charge of the hospital (in the absence of the superintendent) may consent to the medical treatment of or a surgical operation on a child if-

- (a) the treatment or operation is necessary to preserve the life of the child or to save the child from serious or lasting physical injury or disability; **AND**
- (b) the need for the treatment or operation is so urgent that it cannot be deferred for the purpose of obtaining consent that would otherwise have been required

Consent by Minister (Social Development)

The Minister (Social Development) may consent to the medical treatment of, or surgical operation

- 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.
- If the child unreasonably refuses to give consent.

“Unreasonableness” would differ from case to case. An example, though, would be where the parents of a child who are Jehovah’s Witnesses refuse a blood transfusion for a child. An example of a case where a 11 year old child tests positive for HIV, but refuses to disclose the details thereof to his/her parent or guardian. However, prior to disclosing information to the parent / guardian in the latter case, the “best interests of the child” must be taken into account by the health care worker concerned.

Consent by the High Court

Section 129 (9) re-iterates that the High Court remains the Upper Guardian of children and may be approached for necessary relief.

Section 130 - HIV Testing of Children (effective as of 1 July 2007)

A child may be tested for HIV if testing is in the best interests of the child and consent is given by the child or the child’s parent or caregiver.

If the child is over 12 years the child can give consent.

If the child is under 12 years and is sufficiently mature enough to understand the benefits, risks and social implications of the test, then the child can consent him or herself. If the child is not mature enough then the parent or caregiver must give consent on the child’s behalf.

Other people who can give consent for a child under 12, who is not sufficiently maturity to understand the benefits, risks and social implications of such a test, include:

- the provincial head of social development;
- a designated child protection organisation arranging the placement of the child;
- the superintendent or person in charge of a hospital, if the child has no parent or care-giver and there is no designated child protection organisation arranging the placement of the child;
- a children's court, if consent is unreasonably withheld by above, including the child; or the child or the parent or care-giver of the child is incapable of giving consent.

Therefore, even a child under 12 years may consent independently to an HIV test, provided (s)he is of sufficient maturity to understand the benefits, risks and social implications of such a test. However, a problem arises if the child under 12 years is tested HIV positive without parental involvement and then requires treatment. Children under 12 cannot consent to treatment. In this case, it might be in the best interests of the child to breach confidentiality and disclose to the parent / guardian (see Section 13). Once again, the “best interests of the child” must be taken into account by the health care worker, before disclosing any information.

A child may also be tested in the following circumstances:

- if during the course of a medical procedure a **health worker** has had contact with any substance from the child's body that may transmit HIV, and there is a suspicion that the health worker may have contracted HIV due to contact; or
- **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.

Section 132 - pre and post- counselling for HIV testing (effective as of 1 July 2007)

Pre and post testing counselling must be provided to the child. The Act states that **testing may only be done after proper counselling by an appropriately trained person**. If the parent has knowledge of the test or has consented on the child's behalf the parent must also be counselled.

Section 133 – Confidentiality of information on HIV/AIDS status of children (effective as of 1 July 2007)

Section 133 provides that information on a child's HIV status must be kept confidential. It does *not* state that practitioners can make an exception when maintaining such confidentiality is not in the best interests of the child. To break this rule is an offence. This could create problems where a child under 12 years can consent to take an HIV test and the results are positive. A child under 12 cannot consent to treatment, but can refuse to disclose the results to the parent or guardian. There is no case law or definitive ruling on such a case and doctors are advised to approach such matters with extreme caution.

Section 134 - Access to contraceptives (effective as of 1 July 2007)

Section 134 of the Act states that no person may refuse to sell condoms to a child over the age of 12 years; or to provide a child over the age of 12 years with condoms on request where such condoms are provided or distributed free of charge.

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

Finally, a child who obtains condoms, contraceptives or contraceptive advice in terms of this Act is entitled to confidentiality. However, this is subject to s110(1) which is the section which obliges health practitioners to report suspected cases of physical or sexual abuse, or deliberate neglect of a child to the Department of Social Development or a designated child protection organisation. Therefore, if a health practitioner suspects that a child requesting contraceptives is being sexually abused, the health practitioner is obliged to report in terms of section 110(1).

Section 12 - Social, Cultural and Religious Practices (not yet in effect)

Although not yet in effect, section 12 of the Act crystallizes a child's right not to be subjected to social, cultural and religious practices which are detrimental to his or her well-being. It prohibits genital mutilation or the circumcision of female children, and restricts virginity testing to children over 16 years, with their informed consent. Male circumcision is also prohibited on children under 16 years, unless on medical or religious grounds. Children between the ages of 16 and 18 must be counselled before giving consent to virginity testing or male circumcision. These sections of the Act have not come into effect as yet because regulations are currently being drafted.

Surrogate motherhood (not yet in effect)

The chapter on surrogate motherhood has not come into effect yet. Surrogacy was not regulated in South Africa, until this Act. The main principles of the section are basically the following:

- A written agreement (signed by all parties and entered into in SA) must be confirmed by the High Court
- The commissioning parents are unable to give birth to a child
- At least one commissioning parent to be domiciled in SA
- The surrogate mother, husband / partner must be domiciled in SA (at time of contract), but the court may dispense with this requirement
- Consent to the agreement must be obtained from :
 - Husband, wife or partner (permanent relationship) of commissioning parent, and
 - Husband / partner of surrogate mother
- The gametes of both commissioning parents are to be used, unless that is not possible due to biological, medical or other valid reasons
- The surrogate mother must be suitable to accept parenthood (altruistic purposes) and not use surrogacy as a source of income
- The surrogate mother must have a living child of her own
- Artificial insemination (AI) of the surrogate mother must take place after the agreement is signed and is valid for 18 months only. The agreement cannot be cancelled after AI takes place
- The surrogate mother and relatives are obliged to hand over the child. They have no rights to parenthood or contact with the child and the child has no succession or maintenance rights
- If there is no agreement, the child is deemed to be child of the woman that gave birth
- After the termination of a surrogacy contract, provision is made for compensation of expenses to the surrogate mother

CHILDREN'S AMENDMENT ACT

The Children's Amendment Act [No 41 of 2007] provides for a range of social services for children. It aims to:

- Provide for partial care of children (crèches and nursery schools)
- Provide for early childhood development programmes
- Make further provision regarding the protection of children
- Expand list of professionals that are required by law to report child abuse and neglect
- Give legal recognition to child headed households and provide for adult mentors
- Provide for prevention and early intervention services
- Provide for foster care and introduces the new concept of cluster foster care
- Provide for child and youth care centres and drop-in centres
- Create certain new offences relating to harm to children
- Ensure access to social services for children with disabilities

Section 110(1) - Mandatory reporting of abused or neglected child (not yet in effect)

The Bill expands the range of professionals that are legally obliged to report abuse of children, but limits what must be reported to:

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

Section 110 reads "(1) Any correctional official, **dentist, homeopath**, immigration official, labour inspector, legal practitioner, **medical practitioner, midwife**, minister of religion, **nurse, occupational therapist, physiotherapist, psychologist**, religious leader, **social service professional, social worker, speech therapist**, teacher, **traditional health practitioner**, traditional leader or member of staff or volunteer worker at a partial care facility, drop-in centre or child and youth care centre who on reasonable grounds concludes that a child has been abused in a manner causing physical injury, sexually abused or deliberately neglected, must report that conclusion in the prescribed form to a designated child protection organisation, the provincial department of social development or a police official."

A child who obtains condoms, contraceptives or contraceptive advice is entitled to confidentiality, but if the health practitioner has reasonable grounds to conclude that the child is being sexually abused, the practitioner must make a report in terms of section 110(1). A child who undergoes a termination of pregnancy is also entitled to confidentiality. However, if the health practitioner has reasonable grounds to conclude that the child is being sexually abused, the practitioner must make a report in terms of section 110(1).

Health practitioners can make their report to a child protection organisation such as Child Welfare, the provincial department of social development or a police official.

Section 305(1) - Offences

Section 305(1) creates offences for failure to comply with sections 110(1) reporting of abuse, 133(1) disclosure of HIV status and 134(1) access to condoms. Anyone convicted of one of these offences will be liable to a fine, imprisonment or both.

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Updated: 30 July 2008